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Attorney for Defendant

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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CINDY HOGAN-CROSS,

Plaintiff,

-against-

METROPOLITAN LIFE INSURANCE COMPANY,

Defendant.

----------x

No. 08 CV 00012 (LAK)

ATTORNEY DECLARATION

ARIADNE STAPLES, an attorney duly admitted to practice law before the State and Federal Courts of New York, hereby affirms the following under penalty of perjury:

1. I am Counsel with the Metropolitan Life Insurance Company ("MetLife"), Defendant in this action. As such, I am familiar with the facts and circumstances herein. I submit this Certification in support of MetLife's: 1) Motion to dismiss plaintiffs' Cause of action pursuant to 29 U.S.C. § 1132(a)(3); 2) request for an Order staying the discovery in this action until this motion can be determined; and 3) awarding such other and further relief as this Court deems just and proper.

Procedural History

2. On or about March 14, 2008, Plaintiff filed an Amended Complaint with the Southern District of New York with causes of actions pursuant to 29 U.S.C. § 1132(a)(1)(B) and 29 U.S.C. § 1132(a)(3) alleging that Defendant MetLife breached its fiduciary duty to the plaintiff by failing to grant her claim for long term disability benefits. A true and correct copy of the Amended Complaint is attached hereto as **"Exhibit A."**

3. On or about April 11, 2008, Defendant filed an Answer. A true and correct copy of the Answer is attached hereto as **"Exhibit B."**

4. As the Court is aware, various motions have been filed and decisions rendered by this Court regarding the appropriate parties, the appropriate venue and regarding protracted discovery issues. On July 31, 2008, after a motion to compel discovery by plaintiff, a subsequent decision by the Court, and a motion to reconsider by MetLife, the Court Ordered that MetLife provide voluminous discovery responses as outlined in its Memorandum Opinion. A true and correct copy of the July 31, 2008 Memorandum Opinion is attached hereto as **"Exhibit C."**

5. Due to the extraordinary breadth of discovery, to which MetLife could not timely respond without incurring unreasonably excessive costs, and in keeping with its fiduciary obligations to the plan at issue, MetLife was compelled to grant plaintiff's request for benefits and so informed plaintiff and the Court. Settlement negotiations regarding appropriate attorney's fee and interest continued.

6. Despite a favorable outcome for plaintiff, plaintiff abruptly ceased negotiations regarding these remaining issues and informed the Court that plaintiff

intended to pursue her claim for breach of fiduciary duty under section 1132(a)(3) and sought an order compelling MetLife to comply with the July 31, 2008 Memorandum Opinion.

7. On or about August 12, 2008, the Court issued an Order permitting MetLife to seek dismissal of the remaining cause of action, but nonetheless ordering MetLife to comply with the discovery obligations which would require them produce innumerable documents within a twenty-four hour period. A copy of the August 12, 2008 Order is attached hereto as **"Exhibit D."**

Plaintiff's Cause of Action Under 29 U.S.C. § 1132(a)(3) Should be Dismissed

8. The plan providing benefits to plaintiff is an ERISA plan and hence governed by the statutes and provisions as further discussed in the accompanying Memorandum of Law. True and correct copies of the Summary Plan Description and of the Certification of Insurance are attached hereto as **"Exhibit E"** and **"Exhibit F"** respectively.

9. As is detailed in the accompanying Memorandum of Law, plaintiff's cause of action for breach of fiduciary duty under 29 U.S.C. § 1132(a)(3) is impermissible and must be dismissed.

Discovery Should be Stayed pending a Determination of MetLife's Motion for Summary Judgment to Dismiss Plaintiff's Cause of Action Under 29 U.S.C. § 1132(a)(3)

10. Additionally, as defendant has agreed to make Plaintiff whole, her request for cause of action pursuant to 29 U.S.C. § 1132(a)(3) must fail, and discovery in this matter has been rendered moot and unnecessary. The discovery sought by plaintiff is

extraordinarily extensive and costly and defendant is unable to fully respond to the demands in the time currently allotted.

11. Nevertheless, in a good faith effort to comply with the Court's Order, as far as possible, MetLife has provided Plaintiff with some discovery responses (most notably the claims guidelines specific to the IBM plan and the Agreements between MetLife and the vendors providing the Independent Physician Consultants who reviewed Plaintiff's claim) and respectfully requests that the Court issue an Order staying further discovery until such time that the Court can make a determination regarding this motion. Should the motion be granted, discovery will be rendered unnecessary rendering the time and effort expended to comply with the discovery order wasted.

12. For all the aforesaid reasons, and for the reasons set forth in the accompanying Memorandum of Law submitted herewith, plaintiff's cause of action pursuant to 29 U.S.C. § 1132(a)(3) should be dismissed. MetLife respectfully requests that the Court issue an Order staying discovery until a determination regarding this motion can be made.

Dated: August 13, 2008
Queens, New York

METROPOLITAN LIFE INSURANCE COMPANY

By: s/Ariadne Staples
Ariadne Staples (AS 2839)

Counsel - Law Department
Metropolitan Life Insurance Company
One MetLife Plaza
27-01 Queens Plaza North
Long Island City, NY 11101
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Attorneys for Defendant

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

CINDY HOGAN-CROSS,	:	
	:	08 CV 00012 (LAK)
Plaintiff,	:	
	:	**ECF**
- against -	:	
	:	
METROPOLITAN LIFE INSURANCE COMPANY and INTERNATIONAL BUSINESS SYSTEMS, CORP.	:	**AMENDED COMPLAINT**
	:	
Defendants.	:	

Plaintiff, CINDY HOGAN-CROSS, by and through her attorneys, FRANKEL & NEWFIELD, P.C., as and for her Amended Complaint against Defendants METROPOLITAN LIFE INSURANCE COMPANY ("MetLife") and INTERNATIONAL BUSINESS SYSTEMS, CORP. ("IBM"), hereby sets forth the following:

THE PARTIES

1. At all times hereinafter mentioned, Plaintiff CINDY HOGAN-CROSS, was and still is a resident of the State of Texas.

2. Upon information and belief, at all times hereinafter mentioned, Defendant Met Life is a publicly owned life insurance company and a corporation organized and existing under the laws of the State of New York with its principal place of business at One Madison Avenue, New York, New York.

3. Upon information and belief, at all times hereinafter mentioned, Defendant IBM is a publicly owned and traded corporation organized and existing under the laws of the State of New York, with its principal place of business at New Orchard Road, Armonk, New York.

JURISDICTION AND VENUE

4. Jurisdiction is founded on 28 U.S.C. §1331 because this action arises under 29 U.S.C. §1001 et. seq. (Employee Retirement Income Security Act of 1974, hereinafter "ERISA").

5. Venue in the Southern District of New York is appropriate because both Defendant Met Life and Defendant IBM reside in this judicial district, are subject to personal jurisdiction in this judicial district and maintain contacts in this judicial district sufficient to subject both to personal jurisdiction.

6. Pursuant to 28 U.S.C. §1391(a)(1) and §1391(c), this action is properly venued in the Southern District of New York.

FACTS

7. At all relevant times hereinafter mentioned, Plaintiff was an employee of IBM.

8. During Ms. Hogan-Cross's employment with IBM, Defendant Met Life issued to IBM a long term group disability income policy (hereinafter the "Policy").

9. At all times hereinafter mentioned, said disability policy of insurance was issued for the benefit of certain eligible IBM employees in exchange for the payment of premiums by IBM and/or the employees.

10. At all times mentioned herein, Plaintiff was and is an employee eligible for disability benefits and an insured under the Policy issued by IBM.

11. Said policy issued by IBM provided, among other things, that disability insurance payments will be made to Plaintiff in the event that she becomes disabled.

12. On or about April 20, 2006, during the period within which said Policy was in full force and effect, and while Plaintiff was an eligible employee, Plaintiff became disabled

within the meaning and pursuant to the terms of said Policy.

13. The Social Security Administration has determined that Plaintiff became disabled on April 19, 2006.

14. As of this date, Plaintiff continues to be disabled in that she is unable to perform the duties of her occupation or any gainful occupation taking into account her training, education and experience.

15. Plaintiff's disability is caused by, among other things, fibromyalgia, hypothyroid, migraine, chronic pain, cognitive dysfunction, numbness, as well as the functional limitations caused by these disorders.

16. After receiving the claim forms, Plaintiff filed a claim, cooperated with Defendant MetLife, provided proper proof of loss, and otherwise compiled with the policy terms and conditions regarding the filing of a claim.

17. Pursuant to the policy, MetLife was obligated to commence the periodic payment of monthly benefits to Plaintiff on a timely basis.

18. Met Life accepted Plaintiff's claim for short term disability benefits and paid benefits under the policy for a period of time, thereby admitting that Plaintiff suffered a serious and disabling condition that prevented her from performing the duties of her occupation.

19. At some point thereafter, and despite Plaintiff's continuing total disability, Defendant denied further benefits to Plaintiff and continues to refuse to pay further benefits pursuant to the policy, although payment thereof has been duly demanded.

20. Said refusal on the part of Defendant MetLife is a willful and wrongful breach of the policy terms and conditions.

21. Monthly benefits to Plaintiff are continuing to be due and payable by Defendant MetLife with the passage of each month.

22. Defendant MetLife is a conflicted decision maker because it has a financial interest in the outcome of Plaintiff's claim and has a corporate policy to deny or terminate legitimate claims.

23. Defendant Met Life's structural conflict of interest due to its financial interest in the claim and its corporate policy to deny legitimate claims pervaded its handling of Plaintiff's claim, resulting in a number of procedural irregularities in its claim handling, including but not limited to, the refusal to accept the well supported findings of Plaintiff's medical doctors, misplaced and biased reliance upon limited surveillance observation of Plaintiff that does not depict functional ability to work in any occupation on a sustained basis, the refusal to consider the well supported findings of the Social Security Administration, despite accepting the financial benefit of Plaintiff's award of Social Security Disability benefits, and the failure to consider the significant physical, mental, emotional and stamina requirements or the duties of any occupation for which she is qualified taking into account training, education or experience and her predisability earnings.

24. Defendant Met Life's claim handling resulted in numerous violations of 29 CFR § 2560.503-1, the ERISA regulations governing Plaintiff's claim.

25. Defendant Met Life's claim handling failed to provide Plaintiff with a full and fair review of her claim.

26. Defendant Met Life's claim handling demonstrates a bias against

Plaintiff's claim due to its impact on Defendant Met Life's financial situation and prevented Plaintiff from receiving a full and fair review of her claim.

27. Plaintiff has exhausted all administrative appeals and remedies to the extent they exist pursuant to the conditions of the employee benefit plan.

28. Plaintiff continues to be totally disabled, and monthly benefits are due and owing to him with the passage of each month.

AS AND FOR A SECOND CAUSE OF ACTION

29. Plaintiff repeats, reiterates and realleges each of the allegations contained in paragraphs "1" through "28" with the same force and effect as if set forth more fully herein.

30. Upon information and belief, Plaintiff was eligible for additional employee benefits through her employment with IBM that are directly linked to her eligibility for disability benefits.

31. As a result of the claim determination against Plaintiff, her other employee benefits have been impacted.

AS AND FOR A THIRD CAUSE OF ACTION (ERISA 502(a)3))

32. Plaintiff repeats, reiterates and realleges each of the allegations contained in paragraphs "1" through "31" with the same force and effect as if set forth more fully herein.

33. The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to protect the interests of employees in the administration of their employer's welfare benefit plans. In addition to conferring numerous rights upon plan participants, ERISA imposes duties upon the people and corporations who are responsible for the operation of such plans. By law, plan fiduciaries are required to discharge their duties prudently, diligently, and solely in the interest of the plan's beneficiaries, for the exclusive purpose of providing promised benefits.

34. ERISA requires every employee welfare benefit plan to provide for one or more named fiduciaries who will have "authority to control and manage the operation and administration of the Plan" [29 U.S.C. § 1102 (a)(1)]. Either by operation of law or through the implementation of ERISA plan documents, the employer of Plaintiff delegated its fiduciary responsibility for claims administration to one or more of the named Defendants, either directly or indirectly.

35. Defendant Met Life and its agents has determined or participated in determining the eligibility of Plaintiff for disability benefits and/or had the discretionary authority or discretionary responsibility in the administration of Plaintiff's plan. Accordingly, at all relevant times herein, Defendant Met Life was and is a fiduciary pursuant to ERISA [29 U.S.C. § 1002 (21)].

36. Upon information and belief, Defendant Met Life's implementation and application of the foregoing offending claim's practices has caused and continues to cause harm to Plaintiff in violation of ERISA.

37. By virtue of the conduct described above, Defendant Met Life breached its fiduciary obligations to Plaintiff under ERISA [29 U.S.C. § 1104(a)] to discharge its duties "solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries . . . with the care, skill, prudence, and diligence . . . [of a] prudent man . . . and in accordance with the documents and instruments governing the plan . . . ."

38. By managing, operating and administering ERISA-governed plans in the manner described above, Defendant Met Life has failed to exercise the care of an ordinary prudent person engaged in a similar activity under prevailing circumstances, all in violation of

ERISA [29 U.S.C. § 1104(a)(1)(B)].

39. By the foregoing offending claims practices, Defendant Met Life failed to discharge its fiduciary duties in accordance with plan documents and ERISA's legislative scheme.

40. As a result of the breaches of fiduciary duty as described above, Plaintiff has been harmed and continues to be harmed.

41. As a participant in an ERISA-governed benefit plan, Plaintiff is entitled to appropriate equitable relief under ERISA [29 U.S.C. § 1132(a)(3)] to (a) obtain appropriate injunctive relief immediately stopping the offending and egregious practices that are causing ongoing harm to Plaintiff, and (b) redress the violations of §1104 set forth herein.

42. Plaintiff does not have an adequate remedy at law, inasmuch as any benefit action under ERISA 502(a)(1)(B) will result in having further claim determinations made by Defendant Met Life, who has previously demonstrated an inability to act as a neutral claim evaluator.

WHEREFORE, Plaintiff CINDY HOGAN-CROSS prays that she may have a declaratory judgment herein declaring the rights and other legal relations of the parties hereto regarding the matters set forth in this Amended Complaint specifying the following:

a) Plaintiff is disabled pursuant to the language and within the meaning of the subject policy of insurance issued by Defendant;

b) Defendant Met Life is obligated to pay continuing benefits to Plaintiff pursuant to the policy and shall pay all benefits in arrears due and owing since the denial of benefits, plus interest;

c) Defendants' obligation to pay benefits to Plaintiff shall continue as long as she remains totally disabled, subject to the applicable benefit period in the policy;

d) Pursuant to ERISA §502 et. seq., Plaintiff shall be entitled to recoup his attorney's fees, as well as all other costs and disbursements of this action;

e) Plaintiff shall be entitled to the continuation of her other employee benefits that are linked to her disability status through IBM;

f) Pursuant to ERISA 502(a)(3), Plaintiff shall be entitled to appropriate equitable relief, including the removal of Defendant Met Life as claims administrator, and the imposition upon Defendant IBM of substituting Defendant Met Life as claims administrator;

g) Plaintiff may return to this Court, upon motion, to seek further declaratory relief in the event that it becomes necessary; and

h) Such other and further relief as the Court may deem just and proper.

Dated: Garden City, New York
March 14, 2008

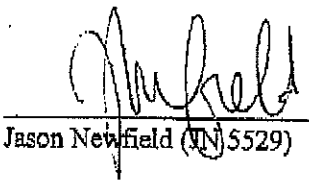
By: _____

Justin C. Frankel (JF-5983)
Jason A. Newfield (JN-5529)
FRANKEL & NEWFIELD, P.C.
585 Stewart Avenue
Garden City, New York 11530
Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I, Jason Newfield, hereby certify that on March 14, 2008, a copy of the foregoing Plaintiff's AMENDED COMPLAINT was mailed by first-class mail to the counsel listed below:

Allan Marcus, Esq.
LESTER SCHWAB KATZ & DWYER, LLP
120 Broadway
New York, NY 10271



Jason Newfield (JN 5529)

LSK&D #: 564-8006 / 1006795
UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
----------x
CINDY HOGAN-CROSS,

Plaintiff,

-against-

METROPOLITAN LIFE INSURANCE COMPANY and INTERNATIONAL BUSINESS SYSTEMS CORP.,

Defendants.
----------x

No. 08 CV 00012 (LAK)

ANSWER TO AMENDED COMPLAINT

Defendant Metropolitan Life Insurance Company ("MetLife"), by its attorneys Lester Schwab Katz & Dwyer, LLP, for its Answer to the Amended Complaint ("Complaint"), states as follows:

1. Denies any knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph "1" of the Complaint.

2. Denies the allegations contained in paragraph "2" of the Complaint, except admit that MetLife is a life insurance company and a corporation organized under the laws of New York State.

3. Denies the allegations contained in paragraph "3" of the Complaint.

4. Declines to plead because the allegations in paragraph "4" of the Complaint state legal conclusions as to which no responsive pleading is required. To the extent that a response is required, admit that this Court has jurisdiction.

5. Denies the allegations contained in paragraph "5" of the Complaint.

6. Declines to plead because the allegations in paragraph "6" of the Complaint state legal conclusions as to which no responsive pleading is required.

7. Denies the allegations contained in paragraph "7" of the Complaint, except admit that, at certain times, plaintiff was employed by IBM.

8. Denies the allegations contained in paragraph "8" of the Complaint.

9. Admits the allegations contained in paragraph "9" of the Complaint.

10. Denies the allegations contained in paragraph "10" of the Complaint, except admit that, at certain times, plaintiff was an employee of IBM and a participant in the IBM Long-Term Disability ("LTD") Benefits Plan (the "Plan").

11. Denies the allegations contained in paragraph "11" of the Complaint.

12. Denies the allegations contained in paragraph "12" of the Complaint.

13. Denies any knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph "13" of the Complaint.

14. Denies any knowledge or information sufficient to form a belief as to the truth of the allegations contained in paragraph "14" of the Complaint.

15. Denies the allegations contained in paragraph "15" of the Complaint.

16. Denies the allegations contained in paragraph "16" of the Complaint, except admit that MetLife received a claim for LTD benefits from plaintiff, along with certain medical records and other information.

17. Denies the allegations contained in paragraph "17" of the Complaint.

18. Denies the allegations contained in paragraph "18" of the Complaint, except admit that MetLife paid plaintiff short-term disability ("STD") benefits.

19. Denies the allegations contained in paragraph "19" of the Complaint, except admit that MetLife denied plaintiff's claim for LTD benefits.

20. Denies the allegations contained in paragraph "20" of the Complaint.

21. Denies the allegations contained in paragraph "21" of the Complaint.

22. Denies the allegations contained in paragraph "22" of the Complaint.

23. Denies the allegations contained in paragraph "23" of the Complaint.

24. Denies the allegations contained in paragraph "24" of the Complaint.

25. Denies the allegations contained in paragraph "25" of the Complaint.

26. Denies the allegations contained in paragraph "26" of the Complaint.

27. Denies the allegations contained in paragraph "27" of the Complaint.

28. Denies the allegations contained in paragraph "28" of the Complaint.

29. Repeats and realleges each of the foregoing responses in paragraphs "1" to "28" above as if fully set forth herein in response to paragraph 29" of the Complaint.

30. Denies the allegations contained in paragraph "30" of the Complaint.

31. Denies the allegations contained in paragraph "31" of the Complaint.

32. Repeats and realleges each of the foregoing responses in paragraphs "1" to "32" above as if fully set forth herein in response to paragraph 29" of the Complaint.

33. Declines to plead because the allegations in paragraph "33" of the Complaint state legal conclusions as to which no responsive pleading is required.

34. Declines to plead because the allegations in paragraph "34" of the Complaint state legal conclusions as to which no responsive pleading is required

35. Admits the allegations contained in paragraph "35" of the Complaint.

36. Denies the allegations contained in paragraph "36" of the Complaint.

37. Denies the allegations contained in paragraph "37" of the Complaint.

38. Denies the allegations contained in paragraph "38" of the Complaint.

39. Denies the allegations contained in paragraph "39" of the Complaint.

40. Denies the allegations contained in paragraph "40" of the Complaint.

41. Denies the allegations contained in paragraph "41" of the Complaint.

42. Denies the allegations contained in paragraph "42" of the Complaint.

43. Denies each and every allegation in the Complaint not specifically admitted herein.

AFFIRMATIVE DEFENSES

44. Plaintiff's lawsuit should be dismissed because it fails to state a claim upon which relief can be granted.

45. Plaintiff's lawsuit should be dismissed because MetLife acted reasonably and properly, and on the basis of substantial evidence in the administrative claim record, in adjudicating plaintiff's claim for disability benefits.

46. Plaintiff's lawsuit should be dismissed because MetLife, a Plan fiduciary, administered plaintiff's claim in accordance with the documents and instruments governing the Plan and in the interest of all Plan participants and beneficiaries.

47. Plaintiff's recovery of benefits, if any, should be reduced by her receipt of Social Security Disability Income Benefits, and other income benefits, as provided by the Plan.

48. Plaintiff is not entitled to recovery because she failed to satisfy all conditions precedent to a claim for benefits in that she has, among other things, failed to present sufficient medical evidence demonstrating disability as defined by the Plan.

49. Plaintiff is not entitled to recovery because she has failed to meet her burden under the terms of the Plan to submit sufficient and satisfactory proof of her alleged disability.

50. Plaintiff's remedies are limited to those afforded by the Employee Retirement Income Security Act of 1974 ("ERISA").

51. Plaintiff's cause of action under ERISA Section 502(a)(3) should be dismissed because she has an adequate remedy for Plan benefits under ERISA Section 502(a)(1)(B).

WHEREFORE, Defendant MetLife demands judgment against Plaintiff dismissing the Amended Complaint with prejudice, together with its attorneys' fees and the costs and disbursements of this action, and for such other and further relief as the Court shall deem just and proper.

Dated: New York, New York
April 11, 2008

Respectfully submitted,

LESTER SCHWAB KATZ & DWYER, LLP

Allan M. Marcus (AM-9027)
120 Broadway
New York, New York 10271
(212) 964-6611
Attorneys for Defendant
Metropolitan Life Insurance Company

TO:

Justin C. Frankel, Esq. (JF-5983)
FRANKEL & NEWFIELD, P.C.
585 Stewart Avenue
Garden City, New York 11530
Attorneys for Plaintiff

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

- x

CINDY HOGAN-CROSS,

Plaintiff,

-against- 08 Civ. 0012 (LAK)

METROPOLITAN LIFE INSURANCE COMPANY, et ano.,

Defendants.

- x

MEMORANDUM OPINION

Appearances:

Justin Corey Frankel
Jason A. Newfield
FRANKEL & NEWFIELD, P.C.
Attorneys for Plaintiff

Allan Michael Marcus
LESTER, SCHWAB, KATZ AND DWYER LLP
Attorney for Defendants

LEWIS A. KAPLAN, *District Judge.*

This is an action to recover benefits under an ERISA plan from defendant Metropolitan Life Insurance Company ("MetLife"). Plaintiff moved to compel discovery. As often has been the case, the defendants resisted any material disclosure, contending that review of its termination of benefits is measured by the arbitrary and capricious standard and, moreover, that such

review is confined to the administrative file. To the extremely limited extent that MetLife addressed the relevance of particular discovery requests,[1] it contended only that interrogatories 14 and 15 and document request 14 were "mainly irrelevant to 'exploring' conflict of interest" and passed quickly to its contention that plaintiff had failed to show that the administrative record was inadequate for the purpose of determining "how a conflict of interest actually influenced MetLife's claim determination." By order dated July 3, 2008, the Court granted plaintiff's motion to compel in significant measure. MetLife now moves for reconsideration of that ruling in significant measure.

Timeliness

MetLife first sought reconsideration by electronically filing, on July 18, 2008, a letter seeking that relief. But Section 13.1 of this Court's Electronic Case Filing Rules and Instructions prohibits the electronic filing of letters. Accordingly, the Clerk rejected the letter. On July 21, 2008, MetLife filed the motion to reconsider that now is before the Court.

S.D.N.Y. Civ. R. 6.3 requires that a motion for reconsideration be filed no later than 10 days after the date of entry of the order in question. As the period in question is less than 11 days, the July Fourth holiday and intervening weekend days are excluded.[2] Accordingly, the last day on which to file a motion for reconsideration was July 18, 2008. While defendants attempted to file on that date, their filing was ineffective in light of the fact that the Clerk properly rejected the filing because it contravened the rules.

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[1] *See* DI 33, at 3.

[2] FED. R. CIV. P. 6(a).

The prohibition of the electronic filing of letters is a carefully considered policy of this Court that serves important purposes. Such communications often are erroneously docketed as motions (although that was not the case here), thus creating difficulties for the Court's ability to track and account for motions. They also burden the docket and the associated electronic storage facilities with unnecessary material. Moreover, the prohibition on electronic filing of letters has been well publicized to the Bar for years, as it appears in written materials disseminated by the Clerk's Office and has been posted on the Court's web site for a long time. Accordingly, the Court is reluctant to relieve MetLife of the consequences of missing the deadline as a result of its failure to comply with such a well-publicized policy. Nonetheless, the Court will treat the present motion as timely notwithstanding this failure *in this instance.* It will not do so in the future for MetLife or for its attorneys, whether in this or other cases.

The Standard

Relief is available under Local Civil Rule 6.3 only if the movant demonstrates that the "'Court overlooked controlling decisions or factual matters that were put before the Court on the underlying motion.'"[3] Such a motion "'may not advance new facts, issues or arguments not previously presented to the court.'"[4] Indeed, as our former Chief Judge Mukasey has written, a party

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[3] *Auscape Int'l v. Nat'l Geographic Soc'y,* No. 02 Civ. 6441(LAK)(HBP), 2003 WL 22127011, at *1 (S.D.N.Y. Sept.15, 2003) (quoting *Am. Alliance Ins. Co. v. Eagle Ins. Co.,* 163 F.R.D. 211, 213 (S.D.N.Y. 1995), *rev'd on other grounds,* 92 F.3d 57 (2d Cir. 1996)).

[4] *Id.* at *1 (quoting *In re Integrated Res. Real Estate Ltd. P'ships Sec. Litig.,* 850 F. Supp. 1105, 1151 (S.D.N.Y. 1994)). *Accord In re Laser Arms Corp. Sec. Litig.,* No. 86 Civ. 3591(JMC), 1990 U.S. Dist. LEXIS 349, at *3-4 (S.D.N.Y. Jan. 17, 1990) (citing *Weissman v. Fruchtman,* 124 F.R.D. 559, 560 (S.D.N.Y. 1989)); *Litton Indus., Inc. v. Lehman Bros.*

seeking reconsideration "is not supposed to treat the court's initial decision as the opening of a dialogue in which that party may then use such a motion to advance new theories or adduce new evidence in response to the court's rulings."[5]

Discussion

1. MetLife first disputes the ruling with respect to document requests 14 and 28-30, interrogatories 14-16, and deposition topics 4 and 6 on the grounds that the time period covered is overbroad and that they do not seek relevant information because "they have nothing to do with conflict of interest."

As an initial matter, the Court declines to reconsider either the time period or other aspects of its ruling on these requests save that part which related to document request 14 and interrogatories 14 and 15 because the arguments now made were not advanced in MetLife's opposition to the motion to compel. MetLife's only objection to the other discovery requests was the bald assertion that depositions and broad discovery inquiries are not permitted "when there is no evidence in the administrative record of any actual conflict."[6] Having declined to challenge on the original motion the relevance of plaintiff's specific requests if, contrary to its argument, discovery is permissible even assuming there is no evidence in the administrative record of any conflict,

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Kuhn Loeb Inc., No. 86 Civ. 6447(JMC), 1989 WL 162315, at *4 (S.D.N.Y. Aug. 4, 1989), *rev'd on other grounds,* 967 F.2d 742 (2d Cir. 1992).

5 *Polsby v. St. Martin's Press, Inc.,* No. 97 Civ. 690(MBM), 2000 WL 98057, at *1 (S.D.N.Y. Jan. 18, 2000) (quotation marks and citation omitted).

6 DI 33, at 2.

MetLife will not be heard to do so now. In any case, even if the Court were disposed to entertain reargument as to these requests, MetLife would fare no better.

In *Metropolitan Life Insurance Co. v. Glenn,*[7] the Supreme Court held that "a plan administrator [that] both evaluates claims for benefits and pays benefits" – precisely MetLife's position here – has a conflict of interest for ERISA purposes.[8] It further made clear that the existence of such a conflict is a factor to be weighed by a court when reviewing the denial of benefits, the significance of which will vary depending upon other circumstances.[9] Moreover, the Court made clear its view that it is neither "necessary [n]or desirable for courts to create special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict."[10] Accordingly, MetLife's notion that discovery is inappropriate in this case because "there is no evidence in the administrative record of any actual conflict," a dubious proposition to begin with before *Glenn*,[11] is misguided. The question here, as in all cases, is whether the discovery sought is relevant in itself or "appears reasonably calculated to lead to the discovery of admissible evidence."[12]

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7 128 S. Ct. 2343 (2008).

8 *Id.* at 2348-50.

9 *Id.* at 2350-52.

10 *Id.* at 2351.

11 *See, e.g.*, *Trussel v. CIGNA Life Ins. Co. of New York*, 552 F. Supp. 2d 387, 389-91 (S.D.N.Y. 2008); *Pelosi v. Schwab Capital Mkts., L.P.*, 462 F. Supp. 2d 503, 510 (S.D.N.Y. 2006).

12 FED. R. CIV. P. 26(b)(1).

The requests at issue here seek evidence concerning approval and termination rates for IBM long term disability claims and statistics regarding long term disability claims administered by MetLife in litigation. To be sure, evidence of high rates of denial and termination of claims, in and of themselves, would prove little or nothing. High rates of denial might reflect only that high proportions of such claims were not meritorious. High rates of termination might reflect only that high proportions of persons who initially were granted disability benefits improved over time and ceased to be eligible for benefits. But that is not to say that evidence of rates of claim denials and benefit terminations would not be reasonably calculated to lead to the discovery of admissible evidence. Evidence of high rates of benefit denials or terminations reasonably could lead to further inquiry as to the reasons for those actions, which might prove either benign or malignant. Accordingly, even if the Court were to grant reconsideration with respect to these requests, it would adhere to its former decision.

2. MetLife next challenges the ruling insofar as it applied to document request 12 and interrogatories 5, 6, and 17. Broadly speaking, those requests, to the extent enforced by the Court, seek information regarding the compensation of "persons involved in evaluating, advising upon, or determining plaintiff's eligibility for continued benefits." MetLife contends the information in question is not relevant.

The bases for and amounts of compensation paid to employees and outside consultants involved in plaintiff's benefit termination itself could prove relevant to plaintiff's claim. Certainly it could lead to other relevant evidence. It could matter a great deal, for example, if an outside reviewer derived all or most of his or her income from MetLife, particularly if that reviewer

frequently recommended denial or termination of benefits.

MetLife relies upon *Abromitis v. Continental Casualty Co.*[13] for the proposition that compensation of an outside consultant is not relevant where the consultant was not the decision-maker. But *Abromitis* is not helpful, particularly in light of *Glenn.* It rested in the first instance on the Fourth Circuit's pre-*Glenn* view that discovery was seldom permissible where the scope of review is the arbitrary and capricious standard. It then relied upon district court cases that concluded that where, as here, a conflict of interest is apparent on the record, discovery as to the extent of the conflict is inappropriate.

This view would not have been persuasive to this Court even before *Glenn.* The ultimate question in these cases is whether the decision in question was arbitrary and capricious. In making that determination, the existence, nature, extent, and effect of any conflict of interest are relevant considerations. A consultant may be compensated in a manner and/or to an extent that creates a motive to recommend against the payment of benefits because such recommendations are believed to serve the interests of the plan administrator. If a decision maker knowingly were to rely on advice from such a consultant, it would be only common sense to say that the decision would command less deference than one made on the basis of unbiased advice or in ignorance of the bias. The categorical or nearly categorical view of *Abromitis* and the cases upon which it relied – that discovery is seldom if ever permissible in these cases, at least if the existence of the conflict inherent in the plan administrator both determining claims and paying benefits is apparent on the record – thus is blind to potentially important information that, at least in some cases, may be critical to the

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[13] 261 F. Supp. 2d 388 (W.D.N.C. 2003), *aff'd without consideration of the point,* 114 Fed. App'x. 57 (4th Cir. 2004).

fair and informed review of benefit claims.

Were there any doubt about this, *Glenn* removed it. It rejected special procedural or evidentiary rules and, in this Court's view, thus abrogated the limitations on discovery unique to ERISA cases that were imposed or applied by such cases as *Abromitis.* Moreover, it provided significant guidance for this case in its comments concerning the manner in which conflicts of interest are to be considered in such cases. It wrote:

> "In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance. The conflict of interest at issue here, for example, should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration. [Citation omitted] It should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits."[14]

Thus, the Court made clear that not all conflicts are created equal. Their significance in any given case depends upon all of the circumstances, including those suggesting a higher or lower likelihood that the conflict affected the decision. Information bearing on the manner in which a conflicted plan administrator compensates outside consultants could be highly pertinent. Maintenance of compensation arrangements that create economic incentives for consultants to recommend denial or termination of benefits would have a material bearing on the likelihood that the administrator's conflict affects its benefit determinations.

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[14] *Glenn,* 128 S. Ct. at 2351.

3. The Court has considered MetLife's other arguments. Even if it were disposed to grant reconsideration, which it is not, it would conclude that they are without merit.

Conclusion

No one denies that speedy, simple, and inexpensive determination of actions seeking review of benefit determinations is desirable. Eliminating or sharply limiting discovery would serve that goal. But that is not the only goal. Congress enacted ERISA to provide unsuccessful claimants with a federal forum for the fair determination of their claims.[15] Pretrial discovery is a part of the process for which Congress opted.

This of course does not mean that limitless, pointless, and needlessly expensive discovery will be a part of every case seeking review of an ERISA benefit determination. Far from it. The Federal Rules of Civil Procedure presumptively limit depositions and interrogatories in all civil cases,[16] and they give district judges ample bases for imposing further limitations.[17] But each case must be considered on its own merits. Blunderbuss attempts to cut off discovery on the ground that it never or rarely should be permitted in these cases, whatever their merits before *Glenn*, no longer have merit.

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15 *See, e.g.*, *Bird v. Shearson Lehman/Am. Express, Inc.*, 926 F.2d 116, 120 (2d Cir.) ("We are aware that one of the means by which Congress sought 'to protect ... participants in employee benefit plans and their beneficiaries' was 'by providing ... ready access to the Federal courts.'") (quoting 29 U.S.C. § 1001(b)), *cert. denied* 501 U.S. 1251 (1991).

16 FED. R. CIV. P.30(a)(2), 33(a)(1).

17 *Id.* 26(b)(2)(A), 26(b)(2)(C), 26(c).

Defendants' motion for reconsideration [docket item 37] is denied in all respects. Even if reconsideration were granted, the Court would adhere to its original decision.

SO ORDERED.

Dated: July 31, 2008

Lewis A. Kaplan
United States District Judge

(The manuscript signature above is not an image of the signature on the original document in the Court file.)

FRANKEL & NEWFIELD, P.C.

MEMO ENDORSED

ATTORNEYS AT LAW

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August 11, 2008

VIA FEDERAL EXPRESS

Honorable Lewis A. Kaplan
United States District Court
500 Pearl Street
New York, New York 10007-1312

Re: Cindy Hogan-Cross v. Metropolitan Life Insurance Company et. al.
U.S. D. Ct., S.D.N.Y. 08 Civ. 0012 (LAK)

Dear Judge Kaplan:

We are the attorneys for the Plaintiff, Cindy Hogan-Cross.

We are in receipt of Defendant's letter to Your Honor dated August 8, 2008, purporting to address the status of the action, and feel compelled to respond. Currently, pursuant to Your Honor's Order, Defendant has until August 13, 2008 to produce documents responsive to Plaintiff's discovery demands. The parties are further ordered to complete all discovery by August 22, 2008, including depositions, which have not been scheduled, despite substantial efforts on Plaintiff's behalf.

In Defendant's letter, counsel advises that by reinstating Plaintiff's claim for benefits, it does not have to comply with the current discovery Order. Defendant fails to advise the Court that Plaintiff's Amended Complaint contains a cause of action under section 502(a)(3) of ERISA seeking injunctive and equitable relief, which has not been impacted by Met Life's voluntary reinstatement of Plaintiff's claim for benefits.

Plaintiff's Amended Complaint seeking relief under 502(a)(3) alleges as follows:

33. The Employee Retirement Income Security Act of 1974 ("ERISA") was enacted to protect the interests of employees in the administration of their employer's welfare benefit plans. In addition to conferring numerous rights upon plan participants, ERISA imposes duties upon the people and corporations who are responsible for the operation of such plans. By law, plan fiduciaries are required to discharge their duties prudently, diligently, and solely in the interest of the plan's beneficiaries, for the exclusive purpose of providing promised benefits.

34. ERISA requires every employee welfare benefit plan to provide for one or more named fiduciaries who will have "authority to control and manage the operation and administration of the Plan" [29 U.S.C. § 1102 (a)(1)]. Either by operation of law or through the implementation of ERISA plan documents, the employer of Plaintiff delegated its fiduciary responsibility for claims administration to one or more of the named Defendants, either directly or indirectly.

35. Defendant Met Life and its agents has determined or participated in determining the eligibility of Plaintiff for disability benefits and/or had the discretionary authority or discretionary responsibility in the administration of Plaintiff's plan. Accordingly, at all relevant times herein, Defendant Met Life was and is a fiduciary pursuant to ERISA [29 U.S.C. § 1002 (21)].

36. Upon information and belief, Defendant Met Life's implementation and application of the foregoing offending claim's practices has caused and continues to cause harm to Plaintiff in violation of ERISA.

37. By virtue of the conduct described above, Defendant Met Life breached its fiduciary obligations to Plaintiff under ERISA [29 U.S.C. § 1104(a)] to discharge its duties "solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries . . . with the care, skill, prudence, and diligence . . . [of a] prudent man . . . and in accordance with the documents and instruments governing the plan . . . ."

38. By managing, operating and administering ERISA-governed plans in the manner described above, Defendant Met Life has failed to exercise the care of an ordinary prudent person engaged in a similar activity under prevailing circumstances, all in violation of ERISA [29 U.S.C. § 1104(a)(1)(B)].

39. By the foregoing offending claims practices, Defendant Met Life failed to discharge its fiduciary duties in accordance with plan documents and ERISA's legislative scheme.

40. As a result of the breaches of fiduciary duty as described above, Plaintiff has been harmed and continues to be harmed.

41. As a participant in an ERISA-governed benefit plan, Plaintiff is entitled to appropriate equitable relief under ERISA [29 U.S.C. § 1132(a)(3)] to (a) obtain appropriate injunctive relief immediately stopping the offending and egregious practices that are causing ongoing harm to Plaintiff, and (b) redress the violations of §1104 set forth herein.

42. Plaintiff does not have an adequate remedy at law, inasmuch as any benefit action under ERISA 502(a)(1)(B) will result in having further claim determinations made by Defendant Met Life, who has previously demonstrated an inability to act as a neutral claim evaluator.

FRANKEL & NEWFIELD, P.C.

Met Life's reinstatement of benefits was the result of it having the proverbial "gun" to its head and not the result of some reasoned decision. Such conduct actually serves to support Plaintiff's cause of action under 502(a)(3).

Accordingly, unless and until that cause of action is either resolved or dismissed, Defendant remains obligated to produce its responsive discovery by August 13, 2008. Toward that end, Plaintiff seeks an Order compelling Defendant to comply with the current Court discovery Order.

Respectfully Submitted,

FRANKEL & NEWFIELD, P.C.

By: _____
Justin C. Frankel (JF5983)

JCF:jpm

cc: Allan Marcus *via Federal Express*

Granted. Defendant is free to seek dismissal on grounds of mootness if it is so advised. In the meantime, it shall comply with its discovery obligations.

SO ORDERED

LEWIS A. KAPLAN, USDJ

8/11/08

About Your Benefits - Income & Asset Protection

Document number: USHR109

July 28, 2005

Notices

This is intended to provide summary plan descriptions of certain benefits plans in which you may be eligible to participate. Complete details can be found in the official plan documents, which remain the final authority and, in the event of a conflict with this book, shall govern in all cases. Due to the ever-increasing complexity of these plans, employees should rely only on the written summary plan descriptions or formal plan documents. The Plan Administrator retains exclusive authority and discretion to interpret the terms of the benefits plans described herein.

IBM reserves the right, at its discretion, to amend, change or terminate any of its benefits plans, programs, practices or policies, as the company requires. Nothing contained in this book shall be construed as creating an express or implied obligation on the part of IBM to maintain such benefits plans, programs, practices or policies. Your benefits at or after retirement may be different from those described herein due to changes made to the IBM Personal Pension Plan or other benefit plans, or the termination of one or more benefit plans.

Because of the need for confidentiality, decisions regarding changes to IBM's benefits plans, programs, practices or policies are generally not discussed or evaluated below the highest levels of management. Managers and their representatives below such levels do not know whether IBM will or will not change or adopt, for example, any particular benefit, separation or retirement plan. Nor are they in a position to advise any employee on, or speculate about, future plans. Employees should make no assumptions about future changes or the impact changes may have on their personal situation until any such change is formally announced by IBM.

Edition

July 28, 2005

This book supersedes all summary plan descriptions found in prior versions of *About Your Company, About Your Financial Future* and *About Your Benefits,* as well as their supplements. It provides cumulative, updated information as of July 28, 2005.

Employees with access to the You and IBM Web site on the IBM intranet should view *About Your Benefits* in the Formal HR Documents section to ensure they have the most current Summary Plan Descriptions.

PREFACE IBM Benefits Programs

The benefits programs provided to you by IBM are a key component of your total compensation and offer a broad foundation upon which you can build in providing for your needs and the well-being of your family. These programs are under continual review and are compared with those of other organizations to maintain their competitiveness and ensure they reflect your needs.

Your benefit plans provide for:

- *Protection* -- against major health care expenses and temporary loss of income due to sickness and accident;

- *Security* -- by providing retirement income, capital accumulation, disability and death benefits;
- *Opportunity* -- to help you balance your work and personal life through vacation and holiday plans, as well as other programs.

You can best decide how to meet your individual needs by being familiar with the coverage provided by IBM and the benefits options available to you. Then you can determine whether to supplement your coverage through IBM with additional individual coverage.

You can also help IBM in the way you use and support the company's benefits programs. For example, while you should always seek professional medical help when it is needed, you can ask questions about the treatment programs your doctor prescribes. You can also maintain a healthy lifestyle. Use pre-admission testing. Ask your doctor about generic drugs. Utilize network providers and facilities and the mail services through the IBM Managed Pharmacy Program. Look into alternative approaches to hospitalization or surgery that may be covered by our plans. It is possible to choose health care that is both medically needed and cost-effective. By containing such costs, you not only reduce your expenses but also help ensure that IBM can continue to provide benefits plans which offer security and protection for you and your family.

Unless otherwise noted, the IBM Plans described in this book pertain to all regular full-time and part-time employees of International Business Machines Corporation, or those subsidiaries of IBM authorized to participate in the Plans, regularly assigned in the United States of America, its territories and possessions and the Commonwealth of Puerto Rico. The Plans do not pertain to other categories of employees, such as supplemental employees.

Length of service, which is the basis for benefit eligibility under several of IBM's benefits plans, is determined according to the company's records and procedures. The Plan Administrator's determination of length of service shall be binding and conclusive. Certain benefit payments also may be considered income subject to taxation under federal and state laws and subject to withholding. Since tax obligations may vary depending on individual circumstances, you should secure help from a qualified tax advisor or from a government tax office if you feel that you require tax assistance.

If you have any questions about your IBM benefits plans, or the information provided above, contact the IBM Employee Services Center (ESC) at 1-800-796-9876 (TTY: 1-800-426-6537), outside U.S. call (919) 784-8646.

PREFACE Benefits Information Provided to You by VRUs and Customer Service Representatives at the Toll-Free Numbers

The Voice Response Units (VRUs) and customer service representatives at the "800," "888" and "877" numbers established by IBM and the various contract administrators are provided as a convenience to you and your beneficiaries. While there is every intention to answer your questions accurately, responses are necessarily given in summary form and may not fully anticipate or describe all nuances surrounding each question. Errors due to miscommunication by either party or other causes are also possible. In any event, neither the VRUs nor the customer service representatives are authorized to give you binding advice.

All details furnished by the VRUs or customer service representatives, including eligibility for benefits, must necessarily be governed by the availability of correct personnel data and the provisions contained in *About Your Benefits* and other Plan documents, as they might be amended and in effect on the date for which benefit coverage is sought. Plan documents, insurance policies, IBM's corrected records, other controlling documents or the applicable law will control in the event of any conflict between the terms of the Plans and the information provided by the VRUs or customer service representatives.

Before calling a customer service center or making a decision based on information you receive from the VRUs or customer service representatives, you should review *About Your Benefits*, your employment records and other Plan documents which are available on request. You may request written information from the Office of the Plan Administrator, IBM Employee Services Center, 3808 Six Forks Road, Raleigh, NC 27609.

If you make a claim for benefits to the Plan Administrator based on what you believe you were told by one of the customer service areas, the Plan Administrator will consider your report along with all other pertinent information.

Table of Contents

1. IBM Short-Term Disability Income Plan for Employees hired prior to 01/01/2004

1.1 Summary

The IBM Short-Term Disability (STD) Income Plan provides continuation of your regular salary when you are absent due to illness or injury. You are eligible for this Plan from the first day of employment.

The Plan provides:

- Regular salary* (minus Workers' Compensation wage payments and/or Social Security Disability Income [SSDI] payments) for each day you are absent, up to a maximum of 26 weeks (1,040 hours) in a period of 12 consecutive months.

*** Regular salary is defined as regular monthly compensation for regularly scheduled hours, not over 40 hours a week. For employees under commission or incentive plans (after 60 consecutive days), "regular monthly compensation" is defined as on-target earnings, the cash compensation you earn when you achieve 100% of your sales performance targets. For executive employees, "regular monthly compensation" is defined as base salary only. The terms of the Executive Annual Incentive Program govern eligibility for annual incentive when an executive employee is eligible for benefits under this plan.**

Note for California employees:

Following the first 26 weeks of your disability, benefits will be equal to 55% of regular salary to a maximum of $840 per week. If you are eligible for and ultimately approved for benefits under the IBM Long-Term Disability Income Plan (LTD), your LTD benefit will be reduced by the benefit amount received under the IBM Short-Term Disability Income Plan. Please consult the IBM Short-Term Disability Income Plan California Supplement available on the IBM intranet in the Legal Notices/Formal HR Documents section of You and IBM at http://w3.ibm.com/hr/.

1.2 What is Covered

If you are unable to work because you are sick or have an accident, your salary will be provided by the IBM Short-Term Disability Income Plan which covers regular employees starting on the first day of employment. "Unable to work" means unable to perform the duties of the job you held at the time of your sickness or accident, or the duties of any other job that IBM determines that you are capable of performing.

While you are employed, and beginning with the first regular workday of reported absence, this Plan will provide you with your regular salary for each day absent up to a maximum of 26 weeks (1,040 hours) in a period of 12 consecutive months. All payments cease on termination of employment. If, for any reason, you receive an overpayment of STD benefits, this overpayment must be repaid to IBM.

Short-Term Disability benefits will not be payable for an illness which can be treated or corrected (in the opinion of GWBS or the physicians selected by IBM) through customary and

accepted medical services, where you refuse to follow the corrective regimen which IBM determines you are reasonably able to follow, in order to correct or limit the illness or disability.

1.3 How the Plan Works

If you are absent typically for more than three consecutive workdays, you must, upon request by IBM Global Well-Being Services or your manager, submit a certificate of disability from your treating physician to be eligible for any further benefits for that particular absence. The certificate your treating physician submits must be a completed Medical Treatment Report (MTR) or equivalent. Based on individual circumstances, managers may request a complete MTR or equivalent for every absence regardless of its duration. Failure to provide a complete MTR or equivalent medical documentation to GWBS within the time set by the Company will result in the discontinuance of STD benefits and can be grounds for management disciplinary action, including termination.

While you are recovering from an illness or injury, you must advise your manager in advance if you will be away from your place of residence for more than five consecutive days and provide a telephone number where you can be reached.

Whether you are at home or elsewhere, you must report to IBM either in person, by phone or by letter at least once a week. In addition, to continue receiving STD Income payments, you must, when requested, furnish a physician's statement (MTR or equivalent) indicating the reasons that continued absence is necessary and provide medical justification acceptable to IBM.

IBM in deciding whether or not you are entitled to benefits, may require an examination by a physician of the company's choice. All IBM determinations regarding your eligibility for benefits are final.

1.3.1 Coordination of Benefits with Workers' Compensation and/or Social Security Disability Income (SSDI) Payments

If your absence is caused by sickness or accident which entitles you to Workers' Compensation and/or Social Security Disability Income (SSDI) payments, only the difference between STD income and the Workers' Compensation and/or SSDI payments will be allowed. (You should apply for SSDI after five months of continued STD absence.) If you receive Workers' Compensation and/or SSDI payments for days you received STD payments, you must reimburse IBM for the STD amount that was duplicated by Workers' Compensation or SSDI.

1.3.2 Return to Work

Where your position is held open by IBM during the time you are receiving Short-Term Disability Income benefits, you will be placed back at that position upon your return to work provided you were continuously employed by IBM during this period and are certified, if required, by IBM Global Well-Being Services as still able to perform the essential functions of the position (with or without such reasonable accommodations as you request, if any).

However, in some cases, particularly those involving a lengthy illness, IBM may decide, for business reasons, to fill your position during the time you are receiving Short-Term Disability Income benefits, or when you are unable to perform the essential functions of your current position. In such cases, IBM will make a reasonable effort to place you in a comparable position at or about the time you are ready to return to work. If such an effort does not produce a match,

or if IBM determines that you are unable to perform the essential functions of such a position (with or without such reasonable accommodations as you request, if any), IBM will use reasonable efforts to locate another position for you which IBM considers the best available job/skill match for you in IBM at that time.

Although IBM might consider positions in other locations and in other business units, IBM may choose to limit its search for a position for you to your currently assigned location and/or your currently assigned business unit. In the event a return offer is made which would be to a position at a location not near your currently assigned location, IBM, at its discretion and depending upon distances as well as other factors, may offer some form of IBM relocation assistance then in effect. Furthermore, the return offer could involve, among other things, a downleveling, a shift change, a career change, and/or a salary reduction. In determining the availability of positions at the time of the expiration of your Short-Term Disability Income benefits, IBM will neither create positions not needed by IBM nor create vacancies by removing other regular employees from their positions. If a position is not available, IBM, at its discretion, may terminate your employment, except if and as precluded by law.

In the event IBM or your business unit conducts an involuntary reduction in force while you are receiving Short-Term Disability Income benefits and eliminates existing positions due to work elimination, staff reduction or restructuring, IBM reserves the right (except to the extent, if any, precluded by law), to terminate your employment in accordance with the terms of the reduction in force. In determining surplus, the criteria that would be applied in your case would be of the same type of criteria applied in the case of actively working employees otherwise similarly situated. IBM Short-Term Disability Income Plan benefits do not continue beyond termination of employment.

If IBM GWBS determines that your condition allows you to return to work, but does not allow you to return to full-time regular status within a reasonable point in time, IBM will convert your status to part-time regular if a part-time regular position for which you are qualified exists. If a position is not available, IBM at its discretion, may terminate your employment except if and as precluded by law. In the alternative, you may be considered for a personal leave of absence. If IBM GWBS determines that the employee's condition allows the employee to return to full-time regular status within a reasonable point in time, STD payments will end at that time and the employee must return to a regular full-time work schedule. IBM's determination regarding what is a reasonable point in time and whether you are qualified for an available position is final.

1.4 IBM Regular Part-time Employee Short-Term Disability Income Plan

The general provisions and benefits previously described in this section also apply to regular part-time employees.

Short-Term Disability Income benefit hours will be adjusted accordingly for part-time employees and employees who convert from full-time to part-time employment. The adjustment will be based on scheduled work hours and any STD usage prior to the conversion.

2. IBM Short-Term Disability Income Plan for Employees Hired 01/01/2004 and later

2.1 Summary

The IBM Short-Term Disability (STD) Income Plan provides continuation of your salary when you are absent due to illness or injury. You are eligible for this Plan from the first day of employment.

The Plan provides:

- Salary* continuation (minus Workers' Compensation wage payments and/or Social Security Disability Income [SSDI] payments) for each day absent, up to a maximum of 26 weeks (1,040 hours) in a period of 12 consecutive months:
  - *100% salary continuation for the first 13 weeks*
  - *66 2/3% salary continuation for an additional 13 weeks*
- After five years of service, company paid short-term disability benefits increase to 100% of pay for 26 weeks.

*Salary is defined as regular monthly compensation for regularly scheduled hours, not over 40 hours a week. For employees under commission or incentive plans (after 60 consecutive days), "regular monthly compensation" is defined as on-target earnings, the cash compensation you earn when you achieve 100% of your sales performance targets. The terms of the Executive Annual Incentive Program govern eligibility for annual incentive when an executive employee is eligible for benefits under this plan.

Note for California employees:

Following the first 26 weeks of your disability, benefits will be equal to 55% of regular salary to a maximum of $840 per week. If you are eligible for and ultimately approved for benefits under the IBM Long-Term Disability Income Plan (LTD), your LTD benefit will be reduced by the benefit amount received under the IBM Short-Term Disability Income Plan. Please consult the IBM Short-Term Disability Income Plan California Supplement available on the IBM intranet in the Legal Notices/Formal HR Documents section of You and IBM at http://w3.ibm.com/hr/.

2.2 What is Covered

If you are unable to work because you are sick or have an accident, your salary will be provided by the IBM Short-Term Disability Income Plan which covers regular employees starting on the first day of employment. "Unable to work" means unable to perform the duties of the job you held at the time of your sickness or accident, or the duties of any other job that IBM determines that you are capable of performing.

While you are employed, and beginning with the first regular workday of reported absence, this Plan will provide you with salary continuation for each day absent up to a maximum of 26 weeks (1,040 hours) in a period of 12 consecutive months. All payments cease on termination of employment. If for any reason, you receive an overpayment of STD benefits, this overpayment must be repaid to IBM.

STD benefits will not be payable for an illness which can be treated or corrected (in the opinion of Global Well Being Services (GWBS) or the physicians selected by IBM) through customary and accepted medical services, where you refuse to follow the corrective regimen which IBM determines you are reasonably able to follow, in order to correct or limit the illness or disability.

2.3 How the Plan Works

If you are absent typically for more than three consecutive workdays, you must, upon request by IBM Global Well Being Services or your manager, submit a certificate of disability from your treating physician to be eligible for any further benefits for that particular absence. The certificate your treating physician submits must be a completed Medical Treatment Report (MTR) or equivalent. Based on individual circumstances, managers may request a complete MTR or equivalent for every absence regardless of its duration. Failure to provide a complete MTR or equivalent medical documentation to GWBS within the time set by the Company will result in the discontinuance of STD benefits and can be grounds for management disciplinary action, including termination.

While you are recovering from an illness or injury, you must advise your manager in advance if you will be away from your place of residence for more than five consecutive days and provide a telephone number where you can be reached.

Whether you are at home or elsewhere, you must report to IBM either in person, by phone or by letter at least once a week. In addition, to continue receiving STD Income payments, you must when requested, furnish a physician's statement (MTR or equivalent) indicating the reasons that continued absence is necessary and provide medical justification acceptable to IBM.

In deciding whether or not you are entitled to benefits, IBM may require an examination by a physician of the company's choice. All IBM determinations regarding your eligibility for benefits are final.

2.3.1 Coordination of Benefits with Workers' Compensation and/or Social Security Disability Income (SSDI) Payments

If your absence is caused by sickness or accident which entitles you to Workers' Compensation and/or Social Security Disability Income (SSDI) payments, only the difference between STD Income and the Workers' Compensation and/or SSDI payments will be allowed. (You should apply for SSDI after five months of continued STD absence). If you receive Workers' Compensation and/or SSDI payments for days you received STD payments, you must reimburse IBM for the STD amount that was duplicated by Workers' Compensation or SSDI.

2.3.2 Return to Work

Where your position is held open by IBM during the time you are receiving Short-Term Disability benefits, you will be placed back at that position upon your return to work provided you were continuously employed by IBM during this period and are certified, if required by IBM Global Well Being Services (GWBS) as still able to perform the essential functions of the position (with or without such reasonable accommodations as you request, if any).

However, in some cases, particularly those involving a lengthy illness, IBM may decide , for business reasons, to fill your position during the time you are receiving Short-Term Disability

Income benefits, or when you are unable to perform the essential functions of your current position. In such cases, IBM will make a reasonable effort to place you in a comparable position at or about the time you are ready to return to work. If such an effort does not produce a match, or if IBM determines that you are unable to perform the essential function of such a position (with or without such reasonable accommodations as you request, if any), IBM will use reasonable efforts to locate another position for you which IBM considers the best available job/skill match for you in IBM at that time.

Although IBM might consider positions in other locations and in other business units, IBM may choose to limit its search for a position for you to your currently assigned location and/or your currently assigned business unit. In the event a return offer is made which would be to a position at a location not near your currently assigned location, IBM, at its discretion and depending upon distances as well as other factors, may offer some form of IBM relocation assistance, at levels then in effect for other similarly situated employees. Furthermore, the return offer could involve, among other things, a downleveling, a shift change, a career change and/or a salary reduction. In determining the availability of positions at the time your short-term disability benefits expire, IBM will neither create positions not needed by IBM nor create vacancies by removing other regular employees from their positions. If a position is not available, IBM, at its discretion, may terminate your employment, except if and as precluded by law.

In the event IBM or your business unit conducts an involuntary reduction in force while you are receiving Short-Term Disability Income benefits and eliminates existing positions due to work elimination, staff reduction or restructuring, IBM reserves the right (except to the extent, if any, precluded by law), to terminate your employment in accordance with the terms of the reduction in force. In determining surplus, the criteria that would be applied in your case would be of the same type of criteria applied in the case of actively working employees otherwise similarly situated. IBM Short-Term Disability Income Plan benefits do not continue beyond termination of employment.

If IBM GWBS determines that your condition allows you to return to work, but does not allow you to return to full-time regular status within a reasonable point in time, IBM will convert your status to part-time regular if a part-time regular position for which you are qualified exists. If a position is not available, IBM at its discretion may terminate your employment except as precluded by law.

Alternatively, you may be considered for a personal leave of absence. If IBM GWBS determines that your condition allows you to return to full-time regular status within a reasonable period of time, STD payments will end at that time and the employee must return to regular full-time work schedule. IBM's determination regarding what is a reasonable point in time and whether you are qualified for an available position is final.

2.4 IBM Regular Part-Time Employee Short-Term Disability Income Plan

The general provisions and benefits previously described in this section also apply to regular part-time employees.

Short-Term Disability Income benefit hours will be adjusted for part-time employees and employees who convert from full-time to part-time employment. The adjustment will be based on scheduled work hours and any STD usage prior to the conversion.

Employees working in California and New Jersey should consult a special addendum for details unique to their state. The California and New Jersey addenda are available on the IBM intranet in the Legal Notices/Formal HR Documents section of the You and IBM home page at http://w3.ibm.com/hr/.

3. IBM Long-Term Disability Plan for Employees Hired Prior to 01/01/2004

3.1 Summary

Under the IBM Long-Term Disability Plan (the "LTD Plan"), you are eligible for a monthly income benefit, subject to the limitations and conditions of the Plan, if you are totally disabled and have completed the waiting period.

The LTD Plan provides 50 percent of regular monthly compensation, and an option to purchase coverage up to 66 2/3 percent, reduced by payments from certain other sources (see "Coordination with Other Sources of Payment" section), with a minimum monthly benefit of $100.

You submit your application for Long-Term Disability benefits directly to Metropolitan Life Insurance Company (Metropolitan Life).

3.2 Who is Eligible

The LTD Plan covers you if you:

- are a regular full-time or regular part-time employee of IBM or a participating domestic, wholly owned subsidiary of IBM; and
- are in an active status or are on an approved leave of absence (other than a military leave of absence or any pre-retirement bridge leave of absence in which you commit to retire at or before the scheduled end of the leave); and
- are regularly assigned in the United States of America, its territories or possessions, or the Commonwealth of Puerto Rico.

3.3 What the Plan Provides

Beginning on the day after the expiration of your waiting period or the last day salary continuance was paid, whichever is later, and while you remain totally disabled, but not beyond the end of the month of the Disability Benefit Period which applies to you, you will receive a monthly LTD Plan benefit depending on the LTD Plan coverage option that you choose.

3.4 How the Plan Works

3.4.1 Monthly Benefit

- IBM automatically provides coverage of 50 percent of your regular monthly compensation at no cost to you.
- You may choose to purchase coverage up to 66 2/3 percent of your regular monthly compensation during annual enrollment. Rates vary based on age and salary, and premiums are deducted on a pre-tax basis. If you do not purchase 66 2/3 percent coverage during annual enrollment, your default coverage will be 50 percent.

- Evidence of insurability is required for participants who elect or default to 50 percent coverage and later want to increase coverage to 66 2/3 percent. When changing options in the LTD Plan, you must be actively at work* for the coverage/change to take effect.

*actively at work means that you are working your regularly scheduled workdays.

3.4.2 Definitions

Under the Long-Term Disability Plan, "totally disabled" means that during the first 12 months after you complete the waiting period, you cannot perform the important duties of your regular occupation with IBM because of a sickness or injury. After expiration of that 12 month period, totally disabled means that, because of a sickness or injury, you cannot perform the important duties of your occupation or of any other gainful occupation for which you are reasonably fit by your education, training or experience. You must be under the appropriate care and treatment of a doctor on a continuing basis. At your own expense, proof of disability, satisfactory to Metropolitan, must be submitted to Metropolitan. "Your regular occupation with IBM" means the regular occupation you had with IBM as of your last day of active status.

"Appropriate Care and Treatment" means medical care and treatment that meet all of the following:

1. It is received from a Doctor whose medical training and clinical experience are suitable for treating your Disability;
2. It is necessary to meet your basic health needs and is of demonstrable medical value;
3. It is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organization and governmental agencies;
4. It is consistent with the diagnosis of your condition; and
5. It's purpose is maximizing your medical improvement.

"Doctor" means a person who: (i) is legally licensed to practice medicine; and (ii) is not related to you. A licensed medical practitioner will be considered a Doctor:

1. if applicable state law requires that such practitioners be recognized for the purposes of certification of disability; and
2. the care and treatment provided by the practitioner is within the scope of his or her license.

For all covered persons, except those who are on a leave of absence, the waiting period means:

- A total of 26 weeks of your regularly scheduled IBM work time that falls within a continuous 12 months during which you are totally disabled and eligible to receive benefits under the IBM Short-Term Disability Income Plan.

For covered employees on an approved leave of absence, the waiting period means:

- A continuous period of 26 weeks in which you are totally disabled and that starts with a day on which you are on an approved leave of absence from IBM and during which you remain on approved leave of absence or you become eligible to receive benefits under the

IBM Short-Term Disability Income Plan. If you become eligible for any other group long-term disability coverage after the first day of your total disability, you cannot complete the waiting period under this provision.

3.4.3 Regular monthly compensation

Your regular monthly compensation is your salary based on your regularly scheduled hours, not exceeding 40 hours a week. If you are under commission or incentive plans, regular monthly compensation means on-target earnings, the cash compensation you earn when you achieve 100 percent of your sales performance target. The amount of your LTD Plan benefit is determined by your last regular targeted monthly compensation amount as of the date you are entitled to first receive benefits under this Plan.

3.4.4 Disability Benefit Period

The Disability Benefit Period applicable to you while you are totally disabled and the Plan is in force is determined in accordance with the following:

Age When LTD Benefit begins	Disability Benefit Period
Prior to Age 60	To Age 65
On or After Age 60	5 years

3.4.5 Minimum monthly benefit

$100.00

3.4.6 Waiver of Premium

While you are receiving LTD Plan benefits, your LTD Plan premiums are waived.

3.4.7 What Is Not Covered

LTD Plan benefits will not be payable for a total disability caused by:

1. Active participation in a riot.
2. Active participation in a war or any warlike action in time of peace.
3. Committing or attempting to commit a felony.

In addition, no LTD Plan benefits will be payable:

1. For a disability which starts within the first 12 months that you are covered under the LTD Plan and which is caused by a pre-existing condition. Pre-existing condition means a sickness or physical condition for which, in the three months immediately before you become covered under the LTD Plan,
   - symptoms existed which would ordinarily cause a person to seek diagnosis, care or treatment; or
   - medical advice or treatment, including prescribed drugs or medicines, was provided to you by a doctor.

   This pre-existing condition limitation will not apply to you if you were:

a. one of a group of individuals hired into IBM from another company in connection with an outsourcing group, merger or acquisition; and

b. continuously covered, during the last 90 days of your employment with that company (or for the entire term of such employment if less), under one or (concurrently or consecutively) multiple public or private group disability plans – other than Workers' Compensation Plans and the Social Security Disability Income Plan – under which the maximum benefit period was no less than 52 weeks; and

c. an employee of IBM, that has been continuously covered, throughout the term of such employment, under one or (concurrently or consecutively) multiple public or private group disability plans – other than Workers' Compensation plans and the Social Security Disability Income Plan – under which the maximum benefit period was less than 52 weeks.

2. For any period of time during which you are engaged in employment for wage or profit, except the first 24 months of employment which results in rehabilitation earnings. Rehabilitation earnings may be extended beyond 24 months when deemed appropriate by Metropolitan.

3. Monthly benefits are not payable for any period of your disability while you are confined in a penal or correctional institute.

4. Monthly benefit payments will cease on the date you refuse to participate in a Rehabilitation Program in which Metropolitan determines you are able to participate. Rehabilitation Program means:

   a. a return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified, taking into account your training, education, experience and past earnings; or

   b. participating in vocational training or physical therapy. This must be deemed by one of Metropolitan's rehabilitation coordinators to be appropriate.

5. If you fail to submit satisfactory proof at your expense to Metropolitan, when requested, that your total disability still exists, Metropolitan will have the right, while you are receiving LTD Plan benefits, to have you examined, at Metropolitan's expense, by doctors of Metropolitan's choice when and as often as Metropolitan reasonably chooses.

3.4.8 Coordination with Other Sources of Payment

Eligibility for payment of Social Security Disability Income benefits, or disability benefits under the laws of any state, does not guarantee you benefits under the LTD Plan.

The benefits payable under the LTD Plan will be reduced by:

- the actual or estimated primary Social Security Disability Income benefits which you, your spouse or your child(ren) (if applicable) are (or upon making timely and proper request and submitting due proof, would be) entitled to by reason of your disability (see note below regarding Social Security offsets). Any further increase in the level of Social

Security benefits which becomes effective after you are first entitled to receive Social Security benefits will not reduce your monthly LTD Plan payment.

- any benefits you are entitled to receive under any Workers' Compensation law, occupational disease law, or insurance or other arrangement established to conform to any state or other governmental disability benefits law.
- any benefits you are entitled to receive for loss of earnings or their equivalent under any insurance or other plan pursuant to a motor vehicle No-fault Law. However, your LTD Plan benefits will not be reduced by benefits under a No-fault Law if the No-fault Law requires that LTD Plan benefits be paid first.
- 50 percent of your rehabilitation earnings. After the 24 month period described above, your monthly benefit will be reduced by 100 percent of your earnings while disabled. Rehabilitation earnings mean your wages or profits from employment that Metropolitan accepts as being designed to rehabilitate you during a period of disability. Your LTD Plan benefit will be further reduced by any amount by which 100 percent of your rehabilitation earnings plus any Social Security Disability Income benefits, Workers' Compensation payment or any other type of disability payment exceeds 100 percent of your highest regular monthly compensation in the three years prior to the expiration of the IBM Short-Term Disability Plan benefit.
- the amount of any defined benefit pension plan benefits of IBM and its subsidiaries, that you have elected to receive under the IBM Personal Pension Plan, as applicable, as described in that plan.
- any separation allowance, special separation program payment or other severance payment or separation incentive payment which you are granted or are entitled to receive because of retirement, separation or the start of a pre-retirement bridge leave of absence. "Pre-retirement bridge leave of absence" means any leave of absence during which you will become eligible to retire and for which you must commit, in advance, to retire at or before the scheduled end of the leave of absence.

Note for California employees:

Following the first 26 weeks of your IBM Short-Term Disability, benefits will be equal to 55% of regular salary to a maximum of $840 per week. If you are eligible for and ultimately approved for benefits under the IBM Long-Term Disability Income Plan (LTD), your LTD benefit will be reduced by the benefit amount received under the IBM Short-Term Disability Plan. Please consult the IBM Short-Term Disability Income Plan California Supplement available on the IBM intranet in the Legal Notices/Formal HR Documents section of You and IBM at http://w3.ibm.com/hr/

However, your LTD Plan benefit amount will never be less than $100 per month.

Note: Social Security Disability Offsets:

Your monthly benefit will not be reduced by estimated Social Security disability benefits if:

1. You provide proof that you have applied for Social Security disability benefits;

2. You have signed the reimbursement agreement which confirms that you will repay all overpayments that are due to the IBM LTD Plan and the IBM Short-Term Disability Plan. Arrangements have been made with Metropolitan to assist in the recovery of Social Security disability benefits for the IBM LTD Plan and the IBM Short-Term Disability Plan; and

3. You have signed the form authorizing the Social Security Administration to release information on awards directly to Metropolitan.

If you do not satisfy the above requirements, Metropolitan will reduce your disability benefits by such estimated Social Security disability benefits starting with the first disability benefit payment coincident with the date you are eligible to receive Social Security disability benefits.

3.4.9 Reducing Disability Benefit by the Amount of Social Security Benefits

If there is a reasonable basis for you to apply for benefits under the Federal Social Security Act, you must apply. To apply for Social Security disability benefits means to pursue such benefits until you receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

When you receive approval of your claim from the Social Security Administration:

1. Your LTD Plan monthly benefit will be adjusted to offset the amount of your Social Security monthly benefit including benefit amounts received for your spouse and or child(ren); and

2. You must promptly refund to Metropolitan an amount equal to all overpayments due the IBM LTD Plan and the IBM Short-Term Disability Income Plan. If you do not promptly make such refund to Metropolitan, Metropolitan may reduce or offset against any future LTD Plan benefits payable to you. This includes the minimum benefit.

3.4.10 Awards

You must submit prompt notice and written proof to Metropolitan of any award, including any retroactive award, settlement, compromise or other determination which results in payment or entitlement to any amounts derived from primary SSDI benefits, Workers' Compensation payments, any other disability payments or rehabilitation earnings or earnings replacement benefits.

For any retroactive award, Metropolitan will then compute the amount of future LTD Plan benefits and the amount of any adjusted monthly benefits for the period already paid or credited to you before Metropolitan received notice and proof of retroactive award. The adjusted monthly benefit amount means the difference between:

- The amount of monthly LTD Plan benefits already paid or credited to you for that period of disability; and

- The amount by which monthly LTD Plan benefits would have been reduced had the retroactive award been taken into account when Metropolitan computed the LTD Plan benefits for that period of disability.

If Metropolitan notifies you that the amount of adjusted monthly benefits is less than the amount of monthly LTD Plan benefits already paid or credited to you, then you must promptly refund the difference.

If you do not promptly refund the required amount, Metropolitan may, in addition to other rights Metropolitan may have, reduce the amount of any future benefits payable under this Plan (including the $100.00 minimum benefit) by the amount of the refund.

If you are entitled to additional benefits due to an underpayment, Metropolitan will pay the additional amount in a lump sum.

3.4.11 Plan Limitations

If you are disabled due to one or more of the conditions listed below, your disability benefits will be limited to a lifetime maximum equal to the lesser of:

- **24 months;** or
- the maximum Disability Benefit Period

Your disability benefits will be limited as stated above for the following conditions :

Mental or Nervous Disorder or Disease except for:

- schizophrenia;
- dementia; or
- organic brain disease.

Mental or Nervous Disorder or Disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* as of the date your disability begins. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

Chronic Fatigue Syndrome, and related conditions.

Neuromusculoskeletal and soft tissue disorder, including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the disability has objective evidence of:

- Seropositive Arthritis (an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease)
- Spinal tumors, malignancies or vascular malformations (components of the bony spine or spinal cord)
- Vascular Malformations (abnormal development of blood vessels)
- Radiculopathies (disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology)
- Myelopathies (disease of the spinal cord supported by objective clinical findings of spinal cord pathology)

- Traumatic Spinal Cord Necrosis (injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis)
- Musculopathies (disease of muscle fibers, supported by pathological findings on biopsy or electromyography (EMG)

3.4.12 For Disability Due to Alcohol, Drug or Substance Abuse or Addiction

If you are disabled due to alcohol, drug or substance abuse or addiction, your LTD Plan benefits will be limited to one occurrence of approved disability during your lifetime. During your disability, you are required to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a Doctor.

Metropolitan will end LTD Plan benefits at the earliest of:

- The date you receive 24 months of disability benefit payments;
- The date you cease or refuse to participate in the recovery program referred to above; or
- The date you complete such recovery program.

3.4.13 Participation in an Approved Rehabilitation Plan

Rehabilitation Program means a program that has been approved by Metropolitan for the purpose of helping you return to work.

It may include, but is not limited to, your participation in one or more of the following activities:

- Return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings;
- On-site job analysis;
- Job modification/accommodation;
- Training to improve job-seeking skills;
- Vocational assessment;
- Short-term skills enhancement;
- Vocational training; or Restorative therapies to improve functional capacity to return to work

3.4.14 Return to Work

In the event of a remission or recovery from your disability, you must contact Metropolitan at 1-800-638-0064 and the IBM Employee Services Center at 1-800-796-9876. You must also contact your local Global Well-Being Services (GWBS) department if you wish to be considered for return to active employment after receiving LTD Plan benefits. If you are approved for return to work, IBM will attempt to place you in a position that will use your previous experience and education. However, no commitment can be made as to whether any positions for which you qualify will be available, or to the responsibilities or location of any such positions.

In the event that you again become actively employed with IBM after having received benefits under the LTD Plan and you subsequently become disabled again, eligibility for further disability benefits will depend on the nature of the later disability and the period of elapsed time from the original disability. Specifically, if the later disability is due to the same or related cause

or causes as the original disability and occurs within 90 days following your return to active work, such disability will be considered a continuation of the previous disability.

3.4.15 Taxation of Benefits

LTD Plan benefits are subject to federal income tax reporting and withholding requirements. Shortly after the end of each calendar year, you will be issued a W-2 form showing the taxable disability benefits paid and the amount of taxes withheld. State income tax laws vary and benefits will be reported to state tax authorities where required. **LTD benefits are paid with pretax dollars.**

3.4.16 How to File a Claim

The forms necessary to file a claim for LTD Plan benefits may be obtained directly from Metropolitan at 1-800-638-0064. LTD Plan applications are also available at NetBenefits http://netbenefits.com.

The instructions included in the claim package should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

You must complete the "Statement of Employee" form and your doctor must complete the "Statement of Attending Physician" form and return it to you. You must send these and other applicable forms to Metropolitan at the address shown on the claim package. You must send the "Statement of Employer – Application for LTD Benefits" to your line manager at IBM for completion, who will then forward the form to Metropolitan. When the claim has been processed, you will receive written notification of the benefits payable. If any benefits have been denied, you will receive a written explanation.

3.4.17 Notice and Proof of Claim

In order for your LTD Plan benefits to begin on a timely basis, written notice of injury or sickness on which a claim may be based should, if possible, be given to Metropolitan three months prior to the date you would be entitled to first receive LTD Plan benefits. In no case should this notice be given any later than 12 months after the date you would be entitled to first receive LTD Plan benefits.

Proof of such injury or sickness should, if possible, be provided to Metropolitan within 90 days after the date you would be first entitled to receive LTD Plan benefits. In no case should this proof be provided any later than 12 months after the date you would be entitled to first receive LTD Plan benefits.

Determinations of disability must be based on medical information current at the time you would be entitled to first receive LTD Plan benefits. Do not submit the LTD application for benefits more than three months prior to the date you would be entitled to first receive LTD Plan benefits or it will be considered an incomplete application and will be returned. Metropolitan will ask you to resubmit your application no earlier than three months before and no later than 12 months after the date you would be entitled to first receive LTD Plan benefits.

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as reasonably possible.

Metropolitan has the right, while you are receiving LTD Plan benefits, to have you examined by doctors of Metropolitan's choice when and as often as Metropolitan reasonably chooses. The examination will be at Metropolitan's expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of benefits.

3.4.18 Questions about Claims

If there is any question about a claim payment, you can call Metropolitan's Customer Service number, 1-800-638-0064.

3.4.19 If A Claim is Denied

In the event a claim has been denied in whole or in part, you can request a review of your claim by Metropolitan. This written request for review should be sent to Group Claims Review at the address of the Metropolitan office that processed the claim, within 180 days after you receive notice of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate. Metropolitan will re-evaluate all of the information and you will be informed of the decision in writing within 45 days of receipt of request.

(Also see "ERISA Information" section)

3.4.20 Legal Actions

No legal action may be started to obtain benefits until 60 days after proof is given. No legal action may be started more than two years after the time proof must be given.

3.4.21 Termination of Coverage Under the LTD Plan

Your LTD Plan benefit will end on the earliest of:

- The end of the maximum Disability Benefit Period.
- The date disability benefits end as specified in the Plan Limitations section.
- The date the employee is no longer disabled.
- The date the employee dies.
- The date the employee ceases or refuses to participate in a Rehabilitation Program that Metropolitan requires.
- The date the employee fails to have a medical exam requested by Metropolitan.
- The date the employee fails to provide required proof of continuing disability.
- The date the employee's employment with IBM ends.
- The date the employee is no longer in a class which remains eligible for the LTD Plan.
- The date the LTD Plan ends.

3.4.22 If the LTD Plan Ends or is Modified

IBM reserves the right to end, suspend, or amend the LTD Plan at any time, in whole or in part. If the LTD Plan is amended, the benefits payable could be reduced. In addition, benefits may be discontinued at any time for any group of employees.

If the LTD Plan ends, LTD Plan benefits will be paid until the date the LTD Plan ended, except in the following circumstances:

- If the LTD Plan ends in the calendar year in which you become entitled to first receive LTD Plan benefits, LTD Plan benefits will be payable until the end of that calendar year.
- If the LTD Plan ends during the waiting period and you would have been entitled to first receive LTD Plan benefits in the next calendar year, LTD Plan benefits will be payable until the end of that calendar year.

In no event, however, will benefits be paid beyond the end of the Disability Benefit Period which applies to you.

3.4.23 Plan Funding

If you are entitled to receive LTD Plan benefits, such benefits will be funded by IBM, which may pay such benefits directly or insure all or part of these benefits on a year-to-year basis.

If you are entitled to first receive LTD Plan benefits on or after January 1, 1994:

- Any monthly LTD Plan benefit payable to you under the terms of the LTD Plan through the end of the calendar year in which you are entitled to first receive such benefits will be:
  - insured by Metropolitan to the extent of the monthly benefit amount or $10,000, whichever is less; and
  - funded by IBM to the extent, if any, that the monthly benefit amount exceeds $10,000.
- Any monthly LTD Plan benefit payable to you under the terms of the LTD Plan after the end of the calendar year in which you are entitled to first receive such benefits will be:
  - funded by IBM, which may pay such benefits directly or may insure all or part of these benefits on a year-by-year basis.

3.4.24 ERISA Information

The LTD Plan is administered by Metropolitan Life Insurance Company.

Name of the Plan	The IBM Long-Term Disability Plan
Name and Address of Employer Maintaining the Plan	International Business Machine Corporation New Orchard Road Armonk NY 10504
Employer Identification number	13-0871985
Plan Number	525
Type of Plan	Employee Welfare Plan including: Long-Term Disability Benefits

Claim and ERISA Appeals	Metropolitan Life Insurance Company IBM Disability Claims P.O. Box 14592 Lexington, KY. 40511
Plan Administrator's Business Address and telephone Number	Office of the Plan Administrator Employee Services Center 3808 Six Forks Road Raleigh, NC 27609 Telephone: (800) 796-9876

3.4.25 Agent for Service of Legal Process

For disputes arising under those portions of the LTD Plan insured by Metropolitan Life, service of legal process may be made upon Metropolitan Life at one of its legal offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

For disputes arising under the LTD Plan, service of legal process may be made upon the Plan Administrator.

3.4.26 Fiduciaries

With respect to LTD Plan benefits, the named fiduciaries of the Plan, within the meaning of Section 402(a) of ERISA, with authority to control and manage the operation of the LTD Plan, are as follows:

Named Fiduciary	Area of Fiduciary Responsibility
Metropolitan	Provision of full and fair review of claim denials pursuant to Section 503 of ERISA
Plan Administrator	All other areas not included above

Each named fiduciary may appoint a person or persons other than a named fiduciary to carry out the fiduciary responsibilities of the named fiduciary under the Plan.

The fiduciary responsibilities of the named fiduciaries shall be exercisable severally and not jointly, and each named fiduciary's responsibilities will be limited to the specific areas indicated for such named fiduciary.

3.4.27 Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the LTD Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the LTD Plan and to determine eligibility for and entitlement to LTD Plan benefits in accordance with the terms of the LTD Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

3.4.28 Plan Year

The Plan's fiscal records are kept on a policy year beginning each January 1st and ending on the following December 31st.

4. IBM Long-Term Disability Plan for Employees Hired 01/01/2004 and later

4.1 Summary

Under the IBM Long-Term Disability Plan (the "LTD Plan"), you are eligible for a monthly income benefit, subject to the limitations and conditions of the Plan, if you are totally disabled and have completed the waiting period. The plan design is different for those hired on or after 01/01/2004 and those who were hired before 01/01/2004. There is a minimum monthly benefit of $100. You submit your application for Long-Term Disability benefits directly to Metropolitan Life Insurance Company (Metropolitan Life).

4.2 Who is Eligible

The LTD Plan covers you if you:

- are a regular full-time or regular part-time employee of IBM or a participating domestic, wholly owned subsidiary of IBM; *and*
- are in an active status or are on an approved leave of absence (other than a military leave of absence or any pre-retirement bridge leave of absence in which you commit to retire at or before the scheduled end of the leave); *and*
- are regularly assigned in the United States of America, its territories or possessions, or the Commonwealth of Puerto Rico.

4.3 What the Plan Provides

Beginning on the day after the expiration of your waiting period or the last day salary continuance was paid, whichever is later, and while you remain totally disabled, but not beyond the end of the month of the Disability Benefit Period which applies to you, you will receive a monthly LTD Plan benefit depending on the LTD Plan coverage option that you choose.

4.4 How the Plan Works

4.4.1 Monthly Benefit

You may choose to enroll in one of the following coverage options:

- 50% of regular monthly compensation
- 66 2/3% of regular monthly compensation
- No LTD coverage

If you choose "No LTD coverage", you will not receive salary continuation benefits beyond those offered by the IBM Short-Term Disability Plan.

If you do not choose an LTD coverage option when you are first eligible to enroll, you will be automatically enrolled in 50% income replacement coverage.

Evidence of insurability is required for participants who elect no LTD Plan coverage and later want to elect LTD Plan coverage, or for participants who elect 50% coverage and later want to increase coverage to 66 2/3%.

When enrolling or changing options in the LTD Plan, you must be actively at work* for the coverage/change to take effect.

***actively at work means that you are working your regularly scheduled work days.**

Your monthly LTD Plan benefits may be reduced by deductible sources of income or disability earnings. Some disabilities may not be covered or may be subject to limitations.

4.4.2 Definitions

Under the LTD Plan, "totally disabled" means that during the first 12 months after you complete the waiting period, you cannot perform the important duties of your regular occupation with IBM because of a sickness or injury. After expiration of that 12 month period, totally disabled means that, because of a sickness or injury, you cannot perform the important duties of your occupation or of any other gainful occupation for which you are reasonably fit by your education, training or experience. You must be under the Appropriate Care and Treatment of a Doctor on a continuing basis. At your own expense, proof of disability, satisfactory to Metropolitan, must be submitted to Metropolitan. "Your regular occupation with IBM" means the regular occupation you had with IBM as of your last day of active status.

"Appropriate Care and Treatment" means medical care and treatment that meet all of the following:

1. They are received from a Doctor whose medical training and clinical experience are suitable for treating your disability;
2. They are necessary to meet your basic health needs and is of demonstrable medical value;
3. They are consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organization and governmental agencies;
4. They are consistent with the diagnosis of your condition; and
5. Their purpose is maximizing your medical improvement.

"Doctor" means a person who: (i) is legally licensed to practice medicine; and (ii) is not related to you. A licensed medical practitioner will be considered a Doctor:

- if applicable, state law requires that such practitioners be recognized for the purposes of certification of disability; and
- the care and treatment provided by the practitioner is within the scope of his or her license.

For all covered persons, except those who are on a leave of absence, the "waiting period" means:

- The period of your disability during which Metropolitan does not pay benefits.
- It is a total of 26 weeks of your regularly scheduled IBM work time that falls within a continuous 12 months during which you are disabled and eligible to receive benefits under the IBM Short-Term Disability Plan.

For covered employees on an approved leave of absence, the "waiting period" means:

- The period of your disability during which Metropolitan does not pay benefits.
- It is a continuous period of 26 weeks in which you are disabled and that starts with a day on which you are on an approved leave of absence from IBM and during which you remain on an approved leave of absence or become eligible to receive benefits under the IBM Short-Term Disability Plan. If you become eligible for any other group long-term disability coverage after the first day of your total disability, you cannot complete the waiting period under this provision.

4.4.3 Regular monthly compensation

Your regular monthly compensation is your salary based on your regularly scheduled hours, not exceeding 40 hours a week. If you are under commission or incentive plans, regular monthly compensation means on-target earnings, the cash compensation you earn when you achieve 100% of your sales performance target. The amount of your LTD Plan benefit is determined by your last regular targeted monthly compensation amount as of the date you are entitled to first receive benefits under this Plan.

4.4.4 Disability Benefit Period

The Disability Benefit Period applicable to you while you are totally disabled and the Plan is in force is determined in accordance with the following:

Age When LTD Benefit begins	Disability Benefit Period
Prior to Age 60	To Age 65
On or After Age 60	5 years

4.4.5 Minimum monthly benefit

$100.00

4.4.6 Waiver of Premium

While you are receiving LTD Plan benefits, your LTD Plan premiums are waived.

4.4.7 What Is Not Covered

LTD Plan benefits will not be payable for a total disability caused by:

1. Active participation in a riot.
2. Active participation in a war or any warlike action in time of peace.
3. The commitment of or attempt to commit a felony.

In addition, no LTD Plan benefits will be payable:

1. For a disability which starts within the first 12 months that you are covered under the LTD Plan and which is caused by a pre-existing condition. Pre-existing condition means a sickness or physical condition for which, in the three months immediately before you become covered under the LTD Plan,
   - symptoms existed which would ordinarily cause a person to seek diagnosis, care or treatment; or
   - medical advice or treatment, including prescribed drugs or medicines, was provided to you by a doctor.

This pre-existing condition limitation will not apply to you if you were:

a. one of a group of individuals hired into IBM from another company in connection with an outsourcing group, merger or acquisition; and

b. continuously covered, during the last 90 days of your employment with that company (or for the entire term of such employment if less), under one or (concurrently or consecutively) multiple public or private group disability plans – other than Workers' Compensation Plans and the Social Security Disability Income Plan – under which the maximum benefit period was no less than 52 weeks; and

c. an employee of IBM, that has been continuously covered, throughout the term of such employment, under one or (concurrently or consecutively) multiple public or private group disability plans – other than Workers' Compensation plans and the Social Security Disability Income Plan – under which the maximum benefit period was less than 52 weeks.

2. For any period of time during which you are engaged in employment for wage or profit, except the first 24 months of employment which results in rehabilitation earnings. Rehabilitation earnings may be extended beyond 24 months when deemed appropriate by Metropolitan.

3. Monthly benefits are not payable for any period of your disability while you are confined in a penal or correctional institute.

4. Monthly benefit payments will cease on the date you refuse to participate in a Rehabilitation Program in which Metropolitan determines you are able to participate. Rehabilitation Program means:

a. a return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified, taking into account your training, education, experience and past earnings; or

b. participating in vocational training or physical therapy. This must be deemed by one of Metropolitan's rehabilitation coordinators to be appropriate.

5. If you fail to submit satisfactory proof at your expense to Metropolitan, when requested, that your total disability still exists, Metropolitan will have the right, while you are receiving LTD Plan benefits, to have you examined, at Metropolitan's expense, by doctors of Metropolitan's choice when and as often as Metropolitan reasonably chooses.

4.4.8 Coordination with Other Sources of Payment

Eligibility for payment of Social Security Disability Income benefits, or disability benefits under the laws of any state, does not guarantee you benefits under the LTD Plan.

The benefits payable under the LTD Plan will be reduced by:

- the actual or estimated primary Social Security Disability Income benefits which you, your spouse or your child(ren) (if applicable) are (or upon making timely and proper

request and submitting due proof, would be) entitled to by reason of your disability (see note below regarding Social Security offsets). Any further increase in the level of Social Security benefits which becomes effective after you are first entitled to receive Social Security benefits will not reduce your monthly LTD Plan payment.

- any benefits you are entitled to receive under any Workers' Compensation law, occupational disease law, or insurance or other arrangement established to conform to any state or other governmental disability benefits law.
- any benefits you are entitled to receive for loss of earnings or their equivalent under any insurance or other plan pursuant to a motor vehicle No-fault Law. However, your LTD Plan benefits will not be reduced by benefits under a No-fault Law if the No-fault Law requires that LTD Plan benefits be paid first.
- 50 percent of your rehabilitation earnings. After the 24 month period described above, your monthly benefit will be reduced by 100 percent of your earnings while disabled. Rehabilitation earnings mean your wages or profits from employment that Metropolitan accepts as being designed to rehabilitate you during a period of disability. Your LTD Plan benefit will be further reduced by any amount by which 100 percent of your rehabilitation earnings plus any Social Security Disability Income benefits, Workers' Compensation payment or any other type of disability payment exceeds 100 percent of your highest regular monthly compensation in the three years prior to the expiration of the IBM Short-Term Disability Plan benefit.
- the amount of any defined benefit pension plan benefits of IBM and its subsidiaries, that you have elected to receive under the IBM Personal Pension Plan, as applicable, as described in that plan.
- any separation allowance, special separation program payment or other severance payment or separation incentive payment which you are granted or are entitled to receive because of retirement, separation or the start of a pre-retirement bridge leave of absence. "Pre-retirement bridge leave of absence" means any leave of absence during which you will become eligible to retire and for which you must commit, in advance, to retire at or before the scheduled end of the leave of absence.

Note for California employees:

Following the first 26 weeks of your IBM Short-Term Disability, benefits will be equal to 55% of regular salary to a maximum of $840 per week. If you are eligible for and ultimately approved for benefits under the IBM Long-Term Disability Income Plan (LTD), your LTD benefit will be reduced by the benefit amount received under the IBM Short-Term Disability Plan. Please consult the IBM Short-Term Disability Income Plan California Supplement available on the IBM intranet in the Legal Notices/Formal HR Documents section of You and IBM at http://w3.ibm.com/hr/

However, your LTD Plan benefit amount will never be less than $100 per month.

Note: Social Security Disability Offsets:

Your monthly benefit will <u>not</u> be reduced by estimated Social Security disability benefits if:

1. You provide proof that you have applied for Social Security disability benefits;
2. You have signed the reimbursement agreement which confirms that you will repay all overpayments that are due to the IBM LTD Plan and the IBM Short-Term Disability Plan. Arrangements have been made with Metropolitan to assist in the recovery of Social Security disability benefits for the IBM LTD Plan and the IBM Short-Term Disability Plan; and
3. You have signed the form authorizing the Social Security Administration to release information on awards directly to Metropolitan.

If you do not satisfy the above requirements, Metropolitan will reduce your disability benefits by such estimated Social Security disability benefits starting with the first disability benefit payment coincident with the date you are eligible to receive Social Security disability benefits.

4.4.9 Reducing Disability Benefit by the Amount of Social Security Benefits

If there is a reasonable basis for you to apply for benefits under the Federal Social Security Act, you must apply. To apply for Social Security disability benefits means to pursue such benefits until you receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

When you receive approval of your claim from the Social Security Administration:

1. Your LTD Plan monthly benefit will be adjusted to offset the amount of your Social Security monthly benefit including benefit amounts received for your spouse and or child(ren); and
2. You must promptly refund to Metropolitan an amount equal to all overpayments due the IBM LTD Plan and the IBM Short-Term Disability Plan. If you do not promptly make such refund to Metropolitan, Metropolitan may reduce or offset against any future LTD Plan benefits payable to you. This includes the minimum benefit.

4.4.10 Awards

You must submit prompt notice and written proof to Metropolitan of any award, including any retroactive award, settlement, compromise or other determination which results in payment or entitlement to any amounts derived from primary SSDI benefits, Workers' Compensation payments, any other disability payments or rehabilitation earnings or earnings replacement benefits.

For any retroactive award, Metropolitan will then compute the amounts of future LTD Plan benefits and the amount of any adjusted monthly benefits for the period already paid or credited to you before Metropolitan received notice and proof of retroactive award. The adjusted monthly benefit amount means the difference between:

- The amount of monthly LTD Plan benefits already paid or credited to you for that period of disability; and
- The amount by which monthly LTD Plan benefits would have been reduced had the retroactive award been taken into account when Metropolitan computed the LTD Plan benefits for that period of disability.

If Metropolitan notifies you that the amount of adjusted monthly benefits is less than the amount of monthly LTD Plan benefits already paid or credited to you, then you must promptly refund the difference.

If you do not promptly refund the required amount, Metropolitan may, in addition to other rights Metropolitan may have, reduce the amount of any future benefits payable under this Plan (including the $100.00 minimum benefit) by the amount of the refund.

If you are entitled to additional benefits due to an underpayment, Metropolitan will pay the additional amount in a lump sum.

4.4.11 Plan Limitations

If you are disabled due to one or more of the conditions listed below, your disability benefits will be limited to a lifetime maximum equal to the lesser of:

- 24 months; or
- the maximum Disability Benefit Period

Your disability benefits will be limited as stated above for:

Mental or Nervous Disorder or Disease except for:

- schizophrenia;
- dementia; or
- organic brain disease.

Mental or Nervous Disorder or Disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* as of the date your disability begins. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

Chronic Fatigue Syndrome, and related conditions

Neuromusculoskeletal and soft tissue disorder, including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the disability has objective evidence of:

- Seropositive Arthritis (an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease)
- Spinal tumors, malignancies or vascular malformations (components of the bony spine or spinal cord).
- Vascular Malformations (abnormal development of blood vessels)
- Radiculopathies (disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology)
- Myelopathies (disease of the spinal cord supported by objective clinical findings of spinal cord pathology)

- Traumatic Spinal Cord Necrosis (injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis)
- Musculopathies (disease of muscle fibers, supported by pathological findings on biopsy or electromyography (EMG).

4.4.12 For Disability Due to Alcohol, Drug or Substance Abuse or Addiction

If you are disabled due to alcohol, drug or substance abuse or addiction, your LTD Plan benefits will be limited to one occurrence of approved disability during your lifetime. During your disability, you are required to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a Doctor.

Metropolitan will end LTD Plan benefits at the earliest of:

- The date you receive **24** months of disability benefit payments;
- The date you cease or refuse to participate in the recovery program referred to above; or
- The date you complete such recovery program.

4.4.13 Participation in an Approved Rehabilitation Plan

Rehabilitation Program means a program that has been approved by Metropolitan for the purpose of helping you return to work.

It may include, but is not limited to, your participation in one or more of the following activities:

- Return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings;
- On-site job analysis;
- Job modification/accommodation;
- Training to improve job-seeking skills;
- Vocational assessment;
- Short term skills enhancement;
- Vocational training; or Restorative therapies to improve functional capacity to return to work

4.4.14 Return to Work

In the event of a remission or recovery from your disability, you must contact Metropolitan at 1-800-638-0064 and the IBM Employee Services Center at 1-800-796-9876. You must also contact your local Global Well-Being Services (GWBS) department if you wish to be considered for return to active employment after receiving LTD Plan benefits. If you are approved for return to work, IBM will attempt to place you in a position that will use your previous experience and education. However, no commitment can be made as to whether any positions for which you qualify will be available, or to the responsibilities or location of any such positions.

In the event that you again become actively employed with IBM after having received benefits under the LTD Plan and you subsequently become disabled again, eligibility for further disability benefits will depend on the nature of the later disability and the period of elapsed time from the original disability. Specifically, if the later disability is due to the same or related cause

or causes as the original disability and occurs within 90 days following your return to active work, such disability will be considered a continuation of the previous disability.

4.4.15 Taxation of Benefits

LTD Plan benefits are subject to federal income tax reporting and withholding requirements. Shortly after the end of each calendar year, you will be issued a W-2 form showing the taxable disability benefits paid and the amount of taxes withheld. State income tax laws vary and benefits will be reported to state tax authorities where required. **LTD benefits are taxed with pretax dollars.**

4.4.16 How to File a Claim

The forms necessary to file a claim for LTD Plan benefits may be obtained directly from Metropolitan at 1-800-638-0064. LTD Plan applications are also available at NetBenefits http://netbenefits.com.

The instructions included in the claim package should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

You must complete the "Statement of Employee" form and your doctor must complete the "Statement of Attending Physician" form and return it to you. You must send these and other applicable forms to Metropolitan at the address shown on the claim package. You must send the "Statement of Employer – Application for LTD Benefits" to your line manager at IBM for completion, who will then forward the form to Metropolitan. When the claim has been processed, you will receive written notification of the benefits payable. If any benefits have been denied, you will receive a written explanation.

4.4.17 Notice and Proof of Claim

In order for your LTD Plan benefits to begin on a timely basis, written notice of injury or sickness on which a claim may be based should, if possible, be given to Metropolitan three months prior to the date you would be entitled to first receive LTD Plan benefits. In no case should this notice be given any later than 12 months after the date you would be entitled to first receive LTD Plan benefits.

Proof of such injury or sickness should, if possible, be provided to Metropolitan within 90 days after the date you would be first entitled to receive LTD Plan benefits. In no case should this proof be provided any later than 12 months after the date you would be entitled to first receive LTD Plan benefits.

Determinations of disability must be based on medical information current at the time you would be entitled to first receive LTD Plan benefits. Do not submit application for benefits more than three months prior to the date you would be entitled to first receive LTD Plan benefits or it will be considered an incomplete application and will be returned. Metropolitan will ask you to resubmit your application no earlier than three months before and no later than 12 months after the date you would be entitled to first receive LTD Plan benefits.

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as reasonably possible.

Metropolitan has the right, while you are receiving LTD Plan benefits, to have you examined by doctors of Metropolitan's choice when and as often as Metropolitan reasonably chooses. The examination will be at Metropolitan's expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of benefits.

4.4.18 Questions about Claims

If there is any question about a claim payment, you can call Metropolitan's Customer Service number, 1-800-638-0064.

4.4.19 If A Claim is Denied

In the event a claim has been denied in whole or in part, you can request a review of your claim by Metropolitan. This written request for review should be sent to Group Claims Review at the address of the Metropolitan office that processed the claim, within 180 days after you receive notice of the claim. When requesting a review, please state the reason you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate. Metropolitan will re-evaluate all of the information and you will be informed of the decision in writing within 45 days of receipt of request.

(Also see "ERISA Information" section)

4.4.20 Legal Actions

No legal action may be started to obtain benefits until 60 days after proof is given. No legal action may be started more than two years after the time proof must be given.

4.4.21 Termination of Coverage Under the LTD Plan

Your LTD Plan benefit will end on the earliest of:

- The end of the maximum Disability Benefit Period.
- The date disability benefits end as specified in the Plan Limitations section.
- The date the employee is no longer disabled.
- The date the employee dies.
- The date the employee ceases or refuses to participate in a Rehabilitation Program that Metropolitan requires.
- The date the employee fails to have a medical exam requested by Metropolitan.
- The date the employee fails to provide required proof of continuing disability.
- The date the employee's employment with IBM ends.
- The date the employee is no longer in a class which remains eligible for the LTD Plan.
- The date the LTD Plan ends.

4.4.22 If the LTD Plan Ends or is Modified

IBM reserves the right to end, suspend, or amend the LTD Plan at any time, in whole or in part. If the LTD Plan is amended, the benefits payable could be reduced. In addition, benefits may be discontinued at any time for any group of employees.

If the LTD Plan ends, LTD Plan benefits will be paid until the date the LTD Plan ended, except in the following circumstances:

- If the LTD Plan ends in the calendar year in which you become entitled to first receive LTD Plan benefits, LTD Plan benefits will be payable until the end of that calendar year.
- If the LTD Plan ends during the waiting period and you would have been entitled to first receive LTD Plan benefits in the next calendar year, LTD Plan benefits will be payable until the end of that calendar year.

In no event, however, will benefits be paid beyond the end of the Disability Benefit Period which applies to you.

4.4.23 Plan Funding

If you are entitled to receive LTD Plan benefits, such benefits will be funded by IBM, which may pay such benefits directly or insure all or part of these benefits.

4.4.24 ERISA Information

The LTD Plan is administered by Metropolitan Life Insurance Company.

Name of the Plan	The IBM Long-Term Disability Plan
Name and Address of Employer Maintaining the Plan	International Business Machine Corporation New Orchard Road Armonk NY 10504
Employer Identification number	13-0871985
Plan Number	525
Type of Plan	Employee Welfare Plan including: Long-Term Disability Benefits
Claim and ERISA Appeals	Metropolitan Life Insurance Company IBM Disability Claims P.O. Box 14592 Lexington, KY. 40511
Plan Administrator's Business Address and telephone Number	Office of the Plan Administrator Employee Services Center 3808 Six Forks Road Raleigh, NC 27609 Telephone: (800) 796-9876

4.4.25 Agent for Service of Legal Process

For disputes arising under the LTD Plan, service of legal process may be made upon Metropolitan at one of its legal office, or upon the supervisory official of the Insurance Department in the state in which you reside.

4.4.26 Fiduciaries

With respect to LTD Plan benefits, the named fiduciaries of the Plan, within the meaning of Section 402(a) of ERISA, with authority to control and manage the operation of the LTD Plan, are as follows:

Named Fiduciary	Area of Fiduciary Responsibility
Metropolitan	Provision of full and fair review of claim denials pursuant to Section 503 of ERISA
Plan Administrator	All other areas not included above

Each named fiduciary may appoint a person or persons other than a named fiduciary to carry out the fiduciary responsibilities of the named fiduciary under the Plan.

The fiduciary responsibilities of the named fiduciaries shall be exercisable severally and not jointly, and each named fiduciary's responsibilities will be limited to the specific areas indicated for such named fiduciary.

4.4.27 Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

4.4.28 Plan Year

The Plan's fiscal records are kept on a policy year beginning each January 1st and ending on the following December 31st.

5. IBM Group Life Insurance

5.1 Summary

During your career with the company, you will be provided with a Group Life Insurance Plan to help supplement your personal life insurance program.

Group Life Insurance (GLI) coverage is equal to one times current annual salary (including your current performance bonus target or current Annual Executive Incentive) rounded to the next higher multiple of $1,000 (if not already a multiple thereof). The coverage maximum is $1,000,000.

5.2 Who Is Eligible

- Regular full-time and part-time employees
- Those on a leave of absence with benefits
- Employees receiving benefits from the IBM Medical Disability Income Plan or the Long-Term Disability Plan

5.3 What is Covered

If you die, the amount of group life insurance then in force is payable to the beneficiary(ies) you name or that is(are) prescribed by the Plan policy.

5.4 How the Plan Works

Your insurance coverage starts on the first day of your regular employment and is equal to one times your current annual salary (as defined by regular compensation), including your current performance bonus target or your current Annual Executive Incentive (if you are eligible for one of these), rounded to the next higher multiple of $1,000 (if not already a multiple thereof). The coverage maximum is $1,000,000.

Note: For employees hired before January 1, 2004, GLI coverage is equal to two-times your current annual salary (as defined by regular compensation), including your current performance bonus target or your current Annual Executive Incentive (if you are eligible for one of these), rounded to the next higher multiple of $1,000 (if not already a multiple thereof). The coverage maximum is $2,000,000.

For employees hired before January 1, 1994, GLI coverage is the greater of the above calculation or the amount of coverage available under the Plan's service-based schedule as of December 31, 1993. (For detail, see IBM Group Life Insurance sub-section entitled "Prior Service-Based Schedule" in this Summary Plan Description.)

For those on a leave of absence with benefits or on disability, your GLI coverage will be based on the annual salary you had on your last day worked (as defined by regular compensation) as a regular active employee, unless you are on a Personal Leave of Absence Work Option of three or more years. Those on a Personal LOA Work Option of three or more years will have coverage based on their current part-time work status.

No Group Life Insurance coverage is provided while you are on a Retirement Bridge Leave of Absence without benefits.

Note: For employees hired before January 1, 2004, upon retirement from IBM before age 65 following a Retirement Bridge Leave of Absence, the amount of your insurance coverage on the date you retire will be one-half the amount for which you were insured prior to the date you went on leave, to a maximum of $25,000 in coverage. When you reach age 65 in retirement, your insurance will be reduced to $5,000 and will remain at that level throughout the rest of your retirement. If you take a Retirement Bridge Leave of Absence without benefits and later retire from IBM at or after age 65 following such a leave, the amount of your insurance coverage on the date you retire will be $5,000.

5.5 Coverage After Active Employment Ceases

Coverage ceases after you retire under the IBM Retirement Plan, begin a Retirement Bridge Leave of Absence without benefits, or leave the company.

Note: For employees hired before January 1, 2004 , who retire from IBM, GLI coverage during retirement (until age 65) is equal to one-half of the amount that was in effect immediately prior to retirement, to a maximum of $25,000. When this retiree reaches age 65 (either at or during retirement), GLI coverage is then reduced to $5,000 and will remain at that level throughout the retirement period.

If you are receiving benefits under the IBM Medical Disability Income Plan (MDIP) or Long-Term Disability Plan (LTD), your Group Life Insurance coverage amount will be determined by your annual salary (as defined by regular compensation) in effect on your last day as an active employee. For those who begin to receive LTD benefits on or after January 1, 1997, the GLI calculation will include a performance bonus target or Annual Executive Incentive, if you were eligible for one of these on your last day worked.

The conditions for converting insurance discussed in this Summary Plan Description also apply to any employee receiving benefits under the IBM Medical Disability Income Plan or Long-Term Disability Plan.

If you should leave, go on a bridge leave of absence without benefits or retire under a resource action or Individual Enhanced Separation Allowance (IESA) you may be eligible for GLI transitional coverage for either 3,6 or 12 months. Your resource action or IESA separation information will specify if the GLI transitional coverage applies. If so, depending on your years of service at the time of your separation, you would retain your GLI benefit coverage and associated imputed income amounts that you had as an active employee.

5.6 Imputed Income

Under current IRS regulations, the value of the premium an employer pays for group life insurance coverage above $50,000 is taxable to the covered employee and, therefore, the employer must apply imputed income and withhold related income taxes. Imputed income is calculated as follows:

1. Total GLI coverage - $50,000 = Amount subject to Imputed Income
2. Amount Subject to Imputed Income / 1,000 = Units of Insurance

3. Units of Insurance x Cost per $1,000 per Month (based on age)* = Monthly Imputed Income
4. Monthly Imputed Income x 12 = Annual Imputed Income

(*The following is the IRS Table used for the age-based cost.)

Age Brackets *	Cost per $1,000 per Month
Under 25	$0.05
25 to 29	0.06
30 to 34	0.08
35 to 39	0.09
40 to 44	0.10
45 to 49	0.15
50 to 54	0.23
55 to 59	0.43
60 to 64	0.66
65 to 70	1.27
70 and older	2.06
* Age is assumed to be attained age on last day of the taxable year.	

EXAMPLE: Employee age 42, employee Date of Hire 2/1/04, Salary $75,000, Performance bonus target 6%, GLI coverage = $80,000. The annual imputed income would be determined as follows:

1. $80,000 - $50,000 = $30,000
2. $30,000 / 1,000 = 30 units (/ = divided by)
3. 30 units x $0.10 = $3.00 monthly imputed income
4. $3.00 x 12 = $36.00 annual imputed income

If this employee was in a 28 percent tax bracket, the additional annual tax liability would be approximately $10.08.

For active employees, appropriate federal, state, local and Social Security taxes will be withheld each pay period. For inactive employees with benefits (other than those out on MDIP or LTD), imputed income will be indicated on a year-end W-2. They are responsible for related tax liabilities.

5.7 Annual Salary as Defined by Regular Compensation

Regular compensation is defined for the purposes of determining the annual salary component of the GLI calculation for (1) the current amount of GLI benefit coverage, and (2) the related imputed income amount for each pay period.

For each pay period, regular compensation means the current regular monthly compensation for regularly scheduled hours, not over 40 hours each week.

For employees **(not including Executives)** on commission (and/or incentive) plans, regular compensation means the monthly on-target earnings (OTE) value.

For Executives on incentive, regular compensation means the greater of the current salary equivalent or the "appropriate Retirement Earnings Master (REM) value." An appropriate REM

value is determined for employees newly on annual executive incentive and those continuing on an annual executive incentive.

Those newly on an annual executive incentive are on incentive at any point in the current year and WERE NOT on this incentive in some part of the prior plan year, or the two consecutive plan years prior, or the three consecutive plan years prior. Regular compensation is the greater of current salary equivalent or current year-to-date REM year plus the annual incentive.

Those continuing on an annual executive incentive are on this incentive at any point in the current plan year and WERE on such incentive in some part of the prior plan year, or the two consecutive plan years prior, or the three consecutive plan years prior. Regular compensation is the greater of current salary equivalent or current year-to-date REM plus the annual incentive or the REM average of the last 1,2, or 3 consecutive plan years prior plus the annual incentive.

For Personal LOA Work Options of three or more years, their GLI benefit and related imputed income will be subject to the non-Personal LOA Work Option definitions for regular compensation (i.e., they are treated like regular part-time employees).

For those on MDIP/LTD or a leave of absence with benefits prior to January 1, 1997, regular compensation is defined as regular monthly salary (salary equivalent) for regularly-scheduled hours, not over 40 hours each week, as of the last day worked. For those who were on Annual Executive Incentive, their last day worked prior to January 1, 1997, their regular compensation is defined as base salary plus incentive.

For those who begin LTD or go out on a leave of absence with benefits on or after January 1, 1997, their GLI coverage amount will be based on the GLI coverage in place as of the last day worked.

5.8 Performance bonus Targets

Employees who are eligible for performance bonus consideration will have their current performance bonus target percent included in the calculation of their GLI benefit coverage amount. Any current performance bonus target percent will remain in effect until a new or different target percent is announced. New target percents will become effective for GLI consideration on either the effective date or announcement date (whichever is later). If one is not eligible for a performance bonus target, or if performance bonus targets are discontinued, the GLI calculation for the benefit coverage and related imputed income amounts, will not include prior targets.

5.9 Waiving Coverage in Excess of $50,000

For those who do not wish to have a GLI coverage level which creates imputed income (and related income tax consequences), opportunities to waive coverage in excess of $50,000 have been or will be provided as follows:

1. In conjunction with the annual Personal Benefits Program (PBP) Open Enrollment, there is an opportunity for employees who are eligible for GLI coverage in excess of $50,000 to either initiate a waiver for that excess coverage or to cancel a current waiver for the new plan year. No action is required during this period if you wish to keep your current GLI status as is.

2. For new hires there is a 30-day period from date of hire to submit a completed and signed waiver form to the ESC if their GLI coverage is in excess of $50,000 and they wish to waive that excess coverage.
3. For those who do not submit a waiver during the annual waiver opportunity (#1) or within 30 days of being newly hired (#2), they must experience a qualified status change consistent with submitting a waiver (within 30 days of the change) in the future.
4. If coverage is less than $50,000, no waiver opportunity is available. If a change in salary (and/or performance bonus targets or Annual Executive Incentive) creates GLI coverage in excess of $50,000, the waiver opportunity becomes available. Employees experiencing this increase in GLI coverage will have 30 days from the effective date of the change to submit their completed and signed waiver form to the ESC.

Once excess GLI coverage is waived, reinstatement of full coverage (based on two times regular annual compensation, including performance bonus target or Annual Executive Incentive, if eligible) will only be allowed for qualified status changes (e.g., marriage, birth/adoption) (#3) or during an annual waiver opportunity (#1). Reinstated GLI coverage will go into effect at the beginning of the new plan year (#1) or the first of the month in which imputed income begins (for other reinstatement opportunities).

The same form is used for both initiating and canceling a waiver. This form is available through the ESC. A completed and signed form must be sent to the ESC for processing within 30 days of a qualified status change, within 30 days of being newly hired, or within the time frame communicated for the annual waiver opportunity.

ANYONE WISHING TO WAIVE GLI COVERAGE IN EXCESS OF $50,000 SHOULD MAKE THIS DECISION VERY CAREFULLY AND ENSURE THAT CONSIDERATION HAS BEEN GIVEN TO PERSONAL SITUATIONS AND THE IMPACT ON DEPENDENTS. CANCELLATION OF A WAIVER IS ALLOWED ONLY WITH CONSISTENT QUALIFIED STATUS CHANGES AND MUST BE SUBMITTED WITHIN 30 DAYS OF THE QUALIFIED EVENT (E.G., MARRIAGE) OR DURING THE PBP OPEN ENROLLMENT.

Qualified status changes that would provide an opportunity to waive GLI coverage in excess of $50,000 are: divorce, legal separation, termination of Domestic Partner relationship, death of a spouse/dependent, gain in life insurance benefits (in excess of $50,000) due to change in job status and/or salary (and related changes in performance bonus targets or Annual Executive Incentives), or loss of dependent, become eligible for GLI transitional coverage..

Qualified status changes that would provide an opportunity to cancel a previously-processed waiver are: divorce, marriage, entering into a Domestic Partner relationship, birth/adoption, going on Long-Term Disability, or becoming eligible for GLI transitional coverage.

Imputed income can also be avoided for the coverage amount assigned to beneficiary designations of tax-exempt charities (i.e., organizations determined by IRS guidelines to conform with Section 501(3) and state- and local government-sponsored organizations, such as public schools, colleges and universities). Changes to Designation of Beneficiary forms can be made at any time and no qualified status change is necessary. These forms are available through the IBM Employee Services Center (ESC). Administrative guidelines for designating such charities are outlined on the Designation of Beneficiary form.

Up to ten charity designations can be made in any whole percentage amount. Such designations do not have to be for the entire GLI coverage amount or the entire excess amount over $50,000. Combinations of charity/non-charity designations are allowed; the imputed income and related taxes will be calculated accordingly. For example, if an employee wants to designate 40 percent of a total GLI coverage amount of $100,000 to a tax-exempt charity, that would leave $10,000 subject to imputed income ($100,000 minus the first $50,000 not subject to imputed income minus $40,000 for the designated charity).

Future salary increases and/or changes in a performance bonus target (or Annual Executive Incentive) could create a higher level of GLI coverage and may introduce imputed income for those who have previously submitted eligible charity designations (in order to avoid imputed income and related tax liabilities). A review of charity designation percentages when these increases and/or changes occur is recommended.

For example: an employee with $100,000 in GLI coverage may designate an eligible charity to receive 50 percent of the proceeds, and thus avoid imputed income entirely. With a salary increase, the GLI coverage amount becomes $110,000. With the current 50 percent designation, $55,000 would go to the charity and not be subject to imputed income. With the remaining $55,000 (50 percent of the coverage), the first $50,000 is not subject to imputed income, but the remaining $5,000 is subject to imputed income. The current 50 percent designation to charity would need to be changed to 55 percent (the nearest whole percentage closest to $60,000) in order to avoid imputed income. With a 55 percent designation, $60,500 would go to the charity and all imputed income would again be avoided. (See "Designating a Beneficiary" for directions on submitting a change.)

If an employee wants to designate all GLI coverage in excess of $50,000 to a tax-exempt charity, this can be written on the beneficiary form and the "%" section should be left blank. Employees who have already submitted a form with percentages, but would prefer to simply designate the excess in this manner, will need to submit a new beneficiary form with this change. Otherwise, they may be required to resubmit a form with recalculated percentages (previously described) whenever the GLI benefit coverage amount increases (e.g., based on a salary increase) and some amount of that coverage then becomes subject to imputed income.

If an employee wants to designate more than one charity for some or all of the GLI coverage in excess of $50,000, this can also be written on the form. In this case, percentages do need to be written on the form with a statement indicating that these percentages are either to be applied against the entire coverage amount or the coverage amount in excess of $50,000.

Additionally, if employees choose tax-exempt charities for some amount of GLI coverage but do not wish to include such charities for their travel accident insurance designation, they will need to submit a separate beneficiary form for Travel Accident Insurance.

5.10 Retroactive Changes Impacting GLI Benefit Coverage and/or Imputed Income

If an employee dies during the period between the effective date of a retroactive GLI factor change and the date the change is processed, the GLI benefit coverage amount will be calculated as follows:

1. If the retroactive GLI factor change creates a GLI benefit increase, the increased coverage amount will be processed and paid to the beneficiary(ies).

   OR

2. If the retroactive GLI factor change creates a GLI benefit decrease, the GLI benefit coverage amount will be calculated based on the factor in effect prior to the factor decrease.

A GLI factor includes any of the following: salary increase, salary decrease, salary band change, division change, age correction, changes in performance bonus targets, IRS age factors, and/or corrections to OTE data (for commissioned or incented employees).

Changes in imputed income amount as a result of a retroactive change in a GLI factor will be effective the next available pay period and imputed income adjustments will be made retroactively by the system.

5.11 Accelerated Death Benefit

In the event of a documented terminal illness and a life expectancy of six months or less, employees will have access to one-half their GLI benefit (but not more than $50,000) in advance of death to use as they wish. The remainder of the GLI benefit will be paid out to the designated beneficiaries as a result of the regular death claim processing. Anyone wishing detail on this process should contact the IBM Employee Services Center at 1-800-796-9876.

To receive this benefit, your GLI must not be assigned. Benefits are available on a voluntary basis only. If you are required by law to use this option to meet the claims of creditors or you are required by a government agency to use this option to apply for, get or keep a government benefit or entitlement, you are not eligible for this benefit.

Eligibility for this benefits ends with your date of separation or retirement.

5.12 Designating a Beneficiary

You can choose your beneficiary and change your beneficiary at any time by completing the Designation of Beneficiary form, which is available from the ESC. The change becomes effective when the completed form is received and processed by the ESC. In the event a beneficiary form is received after the death of the employee, if Prudential has already paid out the GLI benefit, this beneficiary change will not be valid. Be sure you review your copy of your beneficiary designation periodically to make sure your choice is current. If you do not name a beneficiary, or if the beneficiary dies before you and a new beneficiary is not chosen, payments will be made to your spouse, if living; otherwise, payments will be made in equal shares to your surviving children or, if none survives, to your surviving parents, equally. If no spouse, child or parent is then living, payments are made to the executors or administrators of your estate.

It is important to remember that if an employee designates his or her spouse as the beneficiary, and the employee and spouse are later divorced, this former spouse will remain the employee's beneficiary until and unless the employee makes a change. Also remember that if an employee leaves IBM the GLI benefit is discontinued when employment ceases. If the employee is rehired at a later date, any beneficiary designations from the prior employment period are not valid; a new beneficiary would have to be designated.

If you are in doubt about whom you designated as beneficiary, submit a Designation of Beneficiary form. The most recent form received by IBM will always be used to determine designated beneficiaries. If you wish to receive verification of beneficiary information, you must send a written and signed request to Prudential. Your request should include your return address, employee serial number, Social Security number and signature. Prudential's address for beneficiary verification is: Prudential Group Life Administration, 2101 Welsh Road, Dresher, PA 19025.

5.12.1 Form of Benefit Payment (Mode of Settlement)

You may choose a mode of settlement by making a request of Prudential. If you have not chosen a mode of settlement prior to your death, your beneficiary may enter into an agreement with Prudential as to how the group life insurance benefits will be paid. Options include (1) income payments with interest for a specified number of years, (2) income payments with interest for the beneficiary's lifetime, (3) income payments of a stated amount until the fund of principal and interest is used up, (4) a lump-sum payment, or (5) funds may be left with the insurance company with the interest paid as a regular income, (6) money market deposit account, (7) certificates of deposit and (8) a checkwriting account. With this checkwriting feature, beneficiaries will have the option of receiving GLI proceeds in a checking account arrangement. They will be able to write checks as necessary from an interest-bearing account until the fund is depleted. The insurance proceeds may also be paid under more than one option (for example, partly in a lump-sum amount with the balance in monthly installments).

If you are interested in pre-designating one of these modes of settlement, you will need to contact Prudential directly at 1-800-524-0542.

5.13 Converting Group Life Insurance

Whenever your life insurance is reduced or terminates (for example, because of retirement or if you leave the company other than through a divestiture), you can convert a portion or all of the amount discontinued into any one of the forms usually issued by the insurance company, except term insurance in excess of one year or any policy containing disability or other supplementary benefits. For divestitures, conversion may be available depending on the effective date and coverage amount of the insurance plan provided by the new company.

The period of time during which the conversion must be made varies with the situation:

1. If an employee terminates (i.e., leaves the business for reasons other than retirement) or goes on a leave of absence without benefits, then life insurance terminates on the date of the employee's termination and is followed by a 31-day period during which the employee can convert the amount of insurance under this policy. Should the employee die during this 31-day period, the insurance that would have been paid prior to termination would be paid to the beneficiary.
2. If an employee other than one who has been on a Retirement Bridge Leave of Absence without benefits has a reduction in insurance for retirement, then the reduction occurs 31 days following retirement; following this 31-day period, there is a 31-day conversion period during which the employee may elect to convert the amount of the reduction. Should the employee die during the 62 days following retirement, the full amount of insurance which was in force prior to the event of death will be paid to the beneficiary.

3. If a retiree has a reduction in insurance for reaching age 65, then the reduction occurs 31 days after the last work day of the month in which the retiree reaches age 65. Following this 31-day period, there is a 31-day conversion period during which the retiree may elect to convert the amount of the reduction. Should a retiree die during this period, maximum 92 days, the full amount of insurance which was in force prior to the event of death would be paid to the beneficiary.

If you wish to exercise the conversion privilege available under this policy, you must do so within 31 days of the date your insurance ends or is reduced (see above). The individual policy will take effect when the 31-day period ends.

To initiate the conversion, you should contact any local Prudential office or agent, who has information on how to convert your insurance. IBM cannot give you rate information or process your conversion. You will need to complete a GLI Conversion Notice, which may be obtained by calling the IBM Employee Services Center (ESC) at 1-800-796-9876. For general information about converting, you may call Prudential at (973) 548-6061 or toll free at (877) 889-2070 from 9 a.m. to 5 p.m. (Eastern time), Monday through Friday (TTY: 973-548-6079).

As part of the conversion process, you may apply for an individually underwritten policy at the same time. If you apply for such a policy and show satisfactory evidence of good health, it is possible that you may qualify for preferred rates. The process by which one applies for a conversion policy and an individually underwritten policy at the same time is called the Dual Application Process. Under this process, if the evidence of good health is satisfactory, you will be issued the individually underwritten policy; otherwise, you will automatically be issued a conversion policy. The advantages of an individually underwritten policy include the possibility of more favorable rates, a larger selection of plans and the option, at certain ages, of an Accidental Death Benefit in addition to the usual death benefits.

** It is important to note, however, that the conversion policy must be issued and delivered within the United States. If you live outside the United States (this includes Puerto Rico, but not the Virgin Islands or Guam) and wish to convert an individual policy, you must either:

- physically apply for and receive the policy in the United States; or
- designate a person in the United States with the Power of Attorney to apply for the conversion on your behalf.**

5.13.1 How to File a Claim

Your beneficiary will receive from IBM the necessary forms and instructions for filing a claim, including the mode of payment of the life insurance. Upon receipt of the completed forms and documentation, IBM will forward the insurance claim to the insurance carrier for processing and payment of the life insurance proceeds. If the life insurance beneficiary is legally incapable of handling his/her affairs, payments will be made to the responsible entity appointed by the courts.

5.14 Prior Service-Based Schedule

To the extent that the amount of GLI coverage in effect as of December 31, 1993 (for those hired on or before that date) exceeds the amount of GLI coverage as of January 1, 1997, the active

full-time employee benefit schedule is as follows (the benefit for regular part-time employees is 75 percent of all dollar amounts stated):

Period of IBM Service (As of December 31, 1993)	Amount of GLI Coverage
Less than 1 year	$5,000.00
1 year and less than 2 years	6,000.00
2 years and less than 3 years	12,000.00
3 years and less than 4 years	18,000.00
4 years and less than 5 years	24,000.00
5 years and less than 6 years	30,000.00
6 years and less than 7 years	32,000.00
7 years and less than 8 years	34,000.00
8 years and less than 9 years	36,000.00
9 years and less than 10 years	38,000.00
10 years and less than 11 years	40,000.00
11 years and less than 12 years	41,000.00
12 years and less than 13 years	42,000.00
13 years and less than 14 years	43,000.00
14 years and less than 15 years	44,000.00
15 years and less than 16 years	45,000.00
16 years and less than 17 years	45,500.00
17 years and less than 18 years	46,000.00
18 years and less than 19 years	46,500.00
19 years and less than 20 years	47,000.00
20 years and less than 21 years	47,500.00
21 years and less than 22 years	48,000.00
22 years and less than 23 years	48,500.00
23 years and less than 24 years	49,000.00
24 years and less than 25 years	49,500.00
25 years and over	50,000.00

The IBM Group Life Insurance Plan is underwritten by The Prudential Insurance Company of America, Prudential Plaza, Newark, New Jersey.

This is only a summary of the IBM Group Life Insurance Plan and does not cover all the details. In the event a claim is made, the actual wording of the policy will govern.

5.15 Certificate of GLI - Active/Retired Employee (on/after 01/01/2004)

This Certificate replaces any certificate issued to you prior to January 1, 2004 with respect to the Group Coverages described herein.

Certificate of Group Life Insurance

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certifies that subject to the terms and conditions of the Group Policy No. GX-16000 (herein called the Group Policy), it provides the insurance referred to herein for active regular full-time and part-time Employees hired on or after January 1, 2004 by

INTERNATIONAL BUSINESS MACHINES CORPORATION
(Herein called the Employer)

The Group Policy is reinsured in part by the following companies: Aetna Life Insurance Company, Connecticut General Life Insurance Company, Golden State Mutual Life Insurance Company, Metropolitan Life Insurance Company and North Carolina Mutual Life Insurance Company. This reinsurance does not create any direct liability on the part of the reinsuring company to IBM or any person claiming under the Group Policy. The Prudential Insurance Company of America is alone directly liable for the payment of all benefits under the Group Policy.

SCHEDULE OF BENEFITS

The Group Policy's Schedule of Insurance Amounts for regular full-time and part-time employees and Assignment Limitations, Mode of Settlement and Conversion privilege provisions are summarized below. Consult the "About Your Benefits" booklet issued to you by IBM for a further description of the terms and conditions of your IBM coverage.

This Certificate, which is merely evidence of insurance provided under the Group Policy, is furnished in accordance with, and subject in every respect to, the Group Policy which alone constitutes the agreement under which payments are made. The insurance is effective only after the person concerned is eligible for insurance and becomes and remains insured in accordance with the terms, provisions and conditions of the Group Policy.

LIFE INSURANCE

Upon receipt of due written proof of your death, the amount of Group Life Insurance for which you are insured under the Group Policy shall be payable to the beneficiary designated by you on an IBM Designation of Beneficiary form, in accordance with the terms of the Group Policy. Any part of such insurance for which no beneficiary is designated or surviving at your death will be payable in accordance with the terms of the Group Policy.

Schedule of Insurance Amounts.–An Employee's amount of Term Life Insurance under the Group Policy is the amount applicable to his/her Benefit Class under the following table, subject to the further provisions of this Certificate:

Benefit Classes	Amount of Insurance
All Employees	An amount equal to the lesser of (1) and (2): (1) 100% of the Employee's annual Earnings. If the amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. (2) $1,000,000.

Effect of Option to Accelerate Payment of Death Benefits:

The Employee's amount of insurance (as determined in the absence of this provision) will be reduced by the amount of any Terminal Illness Proceeds paid under the Option to Accelerate Payment of Death Benefits.

(continued)

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Continuation Provisions:

For insurance purposes, an Employee's employment will be considered to terminate when the Employee is no longer actively engaged in work on a full-time or part-time basis. However, the Employer may, without discrimination among persons in like circumstances, consider the Employee as not having terminated employment for insurance purposes and as continuing to be a member of the coverage classes for the insurance up to the applicable time limit. The types of absence and time limits for considering an Employee as continuing to be a member of the coverage classes are as follows:

Type of Absence	Time Limit
Leave of absence for reasons other than disability	None
Disability or part-time employment	None
Layoff due to a resource reduction or Individual Enhanced Separation Allowance, based on years of service:	
Less than 5 years	3 months
5 years or more but less than 25 years	6 months
25 years or more	12 months

Assignment Limitations.-- The insurance may be assigned as a gift assignment or as an assignment to a viatical settlement company. An assignment may apply to any of your rights, benefits or privileges. This includes your right to designate a beneficiary or to convert to another policy. Prudential does not assume any responsibility for the validity or sufficiency of any assignment. Prudential shall not be considered to have knowledge of any assignment unless the original or a duplicate is filed with Prudential through IBM.

If there is an assignment in effect but no beneficiary designated by the assignee, any amount of insurance which then becomes payable because of your death will be payable to the assignee. If the assignee is not living, it will be payable to the assignee's estate. In the circumstances described in the two preceding sentences the "Beneficiary Provisions" of the Group Policy do not apply.

Mode of Settlement Provisions.-- You (or your beneficiary if you make no election) may elect payment of the insurance as described in the "About Your Benefits" booklet. Other methods of settlement may be arranged with Prudential. The minimum interest rate for all methods of payment is 2 3/4%. The applicable interest rate will be the rate applied by Prudential to the method of payment selected. Information about the available methods may be obtained from Prudential upon request to IBM.

Conversion Privilege.--If all or part of an Employee's life insurance ends for one of the reasons stated below, the Employee may convert the insurance which ends to an individual policy of life insurance. Evidence of insurability will not be required. The reasons are:

(1) All of the Employee's insurance ends because: the Employee's employment ends; the Employee transfers out of an eligible class; or all term life insurance of the Group Policy for the Employee's class ends by amendment or because the Group Policy ends.

(2) The Employee's amount of insurance is reduced because of: the end of the Employee's membership in an eligible class; or an amendment to the Group Policy that changes the benefits for the Employee's class; or the Employee's age.

Any conversion for one of the above reasons is subject to the rest of this Section.

Availability.--The Employee must apply in writing for the individual policy and pay the first premium within 31 days after the Employee's insurance under the Policy ends or the amount of such insurance is reduced.

These are the exceptions to the above rule:

If the Employee has been given written notice of the conversion privilege more than 15 days, but less than 90 days, after the Employee's insurance under the Policy ends or the amount of such insurance is reduced, the Employee must apply for the individual policy and pay the first premium payment by the forty-fifth day after he/she has been given such notice.

If the Employee has not been given notice of the conversion privilege within 90 days after the Employee's insurance under the Policy ends or the amount of such insurance is reduced, the Employee must apply for the individual policy and pay the first premium by the end of such 90 days.

(continued)

Individual Policy Requirements.-- The individual policy must conform to the following:

Amount: Not more than the following:

(1) If all of the Employee's amount of insurance under the Policy ends, not more than the amount of such insurance when it ends. But, if it ends because all term life insurance of the Group Policy for the Employee's class ends, the total amount will not exceed the total amount of all the Employee's life insurance then ending under the Group Policy reduced by the amount of group life insurance from any carrier for which the Employee is or becomes eligible within the next 45 days.

(2) If the amount of the Employee's insurance under the Policy is reduced, not more than the amount of the reduction.

Form: Any form of a life insurance policy that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

Subject to the exceptions below, this does not include term insurance or a policy with disability or supplementary benefits.

These are the exceptions to the above rule:

The policy may be issued, at the Employee's request, with preliminary term insurance that lasts for one year starting with its effective date.

If the Employee's amount of insurance under the Policy ends due to the Employee's total and permanent disability, the contract may be issued, at the Employee's request, with term insurance without the one-year limit.

Premium: Based on Prudential's rate as it applies to the form and amount, and to the Employee's class of risk and age on its effective date.

Effective Date: The end of the 31 day period during which the Employee may apply for it.

GRP 120602 (16000-1D)

5.16 Certificate of GLI - Active/Retired Employee (prior to 01/01/2004)

This Certificate replaces any certificate issued to you prior to January 1, 2004 with respect to the Group Coverages described herein.

Certificate of Group Life Insurance

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certifies that subject to the terms and conditions of the Group Policy No. GX-16000 (herein called the Group Policy), it provides the insurance referred to herein for active regular full-time and part-time Employees hired before January 1, 2004 (and regular full-time Employees who retire after October 21, 1977 and part-time Employees who retire on and after January 1, 1997) of

INTERNATIONAL BUSINESS MACHINES CORPORATION
(Herein called the Employer)

The Group Policy is reinsured in part by the following companies: Aetna Life Insurance Company, Connecticut General Life Insurance Company, Golden State Mutual Life Insurance Company, Metropolitan Life Insurance Company and North Carolina Mutual Life Insurance Company. This reinsurance does not create any direct liability on the part of the reinsuring company to IBM or any person claiming under the Group Policy. The Prudential Insurance Company of America is alone directly liable for the payment of all benefits under the Group Policy.

SCHEDULE OF BENEFITS

The Group Policy's Schedule of Insurance Amounts for regular full-time and part-time employees and Assignment Limitations, Mode of Settlement and Conversion privilege provisions are summarized below. Consult the "About Your Benefits" booklet issued to you by IBM for a further description of the terms and conditions of your IBM coverage.

This Certificate, which is merely evidence of insurance provided under the Group Policy, is furnished in accordance with, and subject in every respect to, the Group Policy which alone constitutes the agreement under which payments are made. The insurance is effective only after the person concerned is eligible for insurance and becomes and remains insured in accordance with the terms, provisions and conditions of the Group Policy.

LIFE INSURANCE

Upon receipt of due written proof of your death, the amount of Group Life Insurance for which you are insured under the Group Policy shall be payable to the beneficiary designated by you on an IBM Designation of Beneficiary form, in accordance with the terms of the Group Policy. Any part of such insurance for which no beneficiary is designated or surviving at your death will be payable in accordance with the terms of the Group Policy.

Schedule of Insurance Amounts.--An Employee's amount of Term Life Insurance under the Group Policy is the amount applicable to his/her Benefit Class under the following table, subject to the further provisions of this Certificate:

Benefit Classes	Amount of Insurance*
All Employees	An amount equal to the lesser of (1) and (2): (1) 200% of the Employee's an nual Earnings. If the amount is not a multiple of $ 1,000, it will be rounded to the next higher mu ltiple of $1,000. (2) $2,000,000.

* If an Employee was covered for Employee Term Life Insurance under the Group Policy prior to January 1, 1994, the Employee's amount of insurance will be the greater of the amount shown above and the amount of insurance for which he/she was covered prior to January 1, 1994.

(continued)

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Effect of Option to Accelerate Payment of Death Benefits:
The Employee's amount of insurance (as determined in the absence of this provision) will be reduced by the amount of any Terminal Illness Proceeds paid under the Option to Accelerate Payment of Death Benefits.

Limitation and Reduction Provisions:
The amount of insurance applicable to each Retired Employee is determined as follows:

(a) Subject to paragraph (d) below, for all Employees retired before the attained age of 65 other than Employees who are retired as the result of a resource reduction or Individual Enhanced Separation Allowance (IESA), his/her amount of insurance shall be the lesser of: (a) fifty percent (50%) of the amount of insurance applicable to his/her classification as an active Employee under the Group Policy; and (b) $25,000.

This reduced amount shall become effective after the thirty-first day following the day on which he/she retired. The amount of insurance applicable to a Retired Employee shall be $5,000 after the thirty-first day following the last work day of the month during which he/she attains age 65 and while he/she is insured under the Group Policy as a Retired Employee.

(b) Subject to paragraph (d) below, for all Employees retired before the attained age of 65 who are retired as the result of a resource reduction or Individual Enhanced Separation Allowance (IESA), his/her amount of insurance shall be the lesser of: (a) fifty percent (50%) of the amount of insurance applicable to his/her classification as an active Employee under the Group Policy; and (b) $25,000.

This reduced amount shall become effective at the end of the applicable Time Limit shown below:

For Employees retired by the Employer due to a resource reduction or Individual Enhanced Separation Allowance, based on years of service:	Time Limit
Less than 5 years	3 months
5 years or more but less than 25 years	6 months
25 years or more	12 months

The amount of insurance applicable to a Retired Employee shall be $5,000 after the thirty-first day following the last work day of the month during which he/she attains age 65 and while he/she is insured under the Group Policy as a Retired Employee.

(c) Subject to paragraph (d) below, if the Employee retires at or after age 65, his/her amount of insurance shall be $5,000 after the thirty-first day following his/her retirement date, provided he/she is insured under the Group Policy as a Retired Employee.

(d) The amount of insurance applicable to each Retired Employee in accordance with the foregoing provisions hereof, shall be reduced by the amount of insurance applicable to him/her under the Group Policy No. G-I87500P, previously issued to the Employer by The Travelers Insurance Company, on the day before he/she became a Retired Employee.

Assignment Limitations.-- The insurance may be assigned as a gift assignment or as an assignment to a viatical settlement company. An assignment may apply to any of your rights, benefits or privileges. This includes your right to designate a beneficiary or to convert to another policy. Prudential does not assume any responsibility for the validity or sufficiency of any assignment. Prudential shall not be considered to have knowledge of any assignment unless the original or a duplicate is filed with Prudential through IBM.

If there is an assignment in effect but no beneficiary designated by the assignee, any amount of insurance which then becomes payable because of your death will be payable to the assignee. If the assignee is not living, it will be payable to the assignee's estate. In the circumstances described in the two preceding sentences the "Beneficiary Provisions" of the Group Policy do not apply.

Mode of Settlement Provisions.-- You (or your beneficiary if you make no election) may elect payment of the insurance as described in the "About Your Benefits" booklet. Other methods of settlement may be arranged with Prudential. The minimum interest rate for all methods of payment is 2 3/4%. The applicable interest rate will be the rate applied by Prudential to the method of payment selected. Information about the available methods may be obtained from Prudential upon request to IBM.

Conversion Privilege.--If all or part of an Employee's life insurance ends for one of the reasons stated below, the Employee may convert the insurance which ends to an individual policy of life insurance. Evidence of insurability will not be required. The reasons are:

(1) All of the Employee's insurance ends because: the Employee's employment ends; the Employee transfers out of an eligible class; or all term life insurance of the Group Policy for the Employee's class ends by amendment or because the Group Policy ends.

(continued)

(2) The Employee's amount of insurance is reduced because of: the end of the Employee's membership in an eligible class; or an amendment to the Group Policy that changes the benefits for the Employee's class; or the Employee's age.

Any conversion for one of the above reasons is subject to the rest of this Section.

Availability.--The Employee must apply in writing for the individual policy and pay the first premium within 31 days after the Employee's insurance under the Policy ends or the amount of such insurance is reduced.

These are the exceptions to the above rule:

(1) If the Employee has been given written notice of the conversion privilege more than 15 days, but less than 90 days, after the Employee's insurance under the Policy ends or the amount of such insurance is reduced, the Employee must apply for the individual policy and pay the first premium payment by the forty-fifth day after he/she has been given such notice.

If the Employee has not been given notice of the conversion privilege within 90 days after the Employee's insurance under the Policy ends or the amount of such insurance is reduced, the Employee must apply for the individual policy and pay the first premium by the end of such 90 days.

Individual Policy Requirements.-- The individual policy must conform to the following:

Amount: Not more than the following:

(1) If all of the Employee's amount of insurance under the Policy ends, not more than the amount of such insurance when it ends. But, if it ends because all term life insurance of the Group Policy for the Employee's class ends, the total amount will not exceed the total amount of all the Employee's life insurance then ending under the Group Policy reduced by the amount of group life insurance from any carrier for which the Employee is or becomes eligible within the next 45 days.

(2) If the amount of the Employee's insurance under the Policy is reduced, not more than the amount of the reduction.

Form: Any form of a life insurance policy that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

Subject to the exceptions below, this does not include term insurance or a policy with disability or supplementary benefits.

These are the exceptions to the above rule:

(1) The policy may be issued, at the Employee's request, with preliminary term insurance that lasts for one year starting with its effective date.

(2) If the Employee's amount of insurance under the Policy ends due to the Employee's total and permanent disability, the contract may be issued, at the Employee's request, with term insurance without the one-year limit.

Premium: Based on Prudential's rate as it applies to the form and amount, and to the Employee's class of risk and age on its effective date.

Effective Date: The end of the 31 day period during which the Employee may apply for it.

GRP 120602 (16000-1)

5.17 Certificate of GLI - Bridge Leave of Absence (on/after 10/01/1993)

This Certificate replaces any certificate issued to you prior to January 1, 2004 with respect to the Group Coverages described herein.

Certificate of Group Life Insurance

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Certifies that subject to the terms and conditions of the Group Policy No. GX-16000 (herein called the Group Policy), it provides the insurance referred to herein for full-time Employees who were retired by the Employer and reinstated for coverage under the Group Policy after a bridged leave of absence which commenced on or after October 1, 1993.

INTERNATIONAL BUSINESS MACHINES CORPORATION
(Herein called the Employer)

The Group Policy is reinsured in part by the following companies: Aetna Life Insurance Company, Connecticut General Life Insurance Company, Golden State Mutual Life Insurance Company, Metropolitan Life Insurance Company and North Carolina Mutual Life Insurance Company. This reinsurance does not create any direct liability on the part of the reinsuring company to IBM or any person claiming under the Group Policy. The Prudential Insurance Company of America is alone directly liable for the payment of all benefits under the Group Policy.

SCHEDULE OF BENEFITS

The Group Policy's Schedule of Insurance Amounts for regular employees and Assignment Limitations, Mode of Settlement and Conversion privilege provisions are summarized below. Consult the "About your Benefits" booklet issued to you by IBM for a further description of the terms and conditions of your IBM coverage.

This Certificate, which is merely evidence of insurance provided under the Group Policy, is furnished in accordance with, and subject in every respect to, the Group Policy which alone constitutes the agreement under which payments are made. The insurance is effective only after the person concerned is eligible for insurance and becomes and remains insured in accordance with the terms, provisions and conditions of the Group Policy.

LIFE INSURANCE

Upon receipt of due written proof of your death, the amount of Group Life Insurance for which you are insured under the Group Policy shall be payable to the beneficiary designated by you on an IBM Designation of Beneficiary form, in accordance with the terms of the Group Policy. Any part of such insurance for which no beneficiary is designated or surviving at your death will be payable in accordance with the terms of the Group Policy.

Schedule of Insurance Amounts.--An Employee's amount of Term Life Insurance under the Group Policy is the amount applicable to his/her Benefit Class under the following table, subject to the further provisions of this Certificate:

Benefit Classes	Amount of Insurance
All Employees	An amount equal to the lesser of (1) and (2): (1) 50% of the amount for which the Employee was insured as an active Employee. If the amount is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. (2) $25,000.

Effect of Option to Accelerate Payment of Death Benefits:

The Employee's amount of insurance (as determined in the absence of this provision) will be reduced by the amount of any Terminal Illness Proceeds paid under the Option to Accelerate Payment of Death Benefits.

Limitation and Reduction Provisions:

On and after the Employee's attainment of age 65 his/her amount of insurance, shall while he/she is insured under the Group Policy, be $5,000.

(continued)

GRP 120602 (16000-1B)

Assignment Limitations.-- The insurance may be assigned as a gift assignment or as an assignment to a viatical settlement company. An assignment may apply to any of your rights, benefits or privileges. This includes your right to designate a beneficiary or to convert to another policy. Prudential does not assume any responsibility for the validity or sufficiency of any assignment. Prudential shall not be considered to have knowledge of any assignment unless the original or a duplicate is filed with Prudential through IBM.

If there is an assignment in effect but no beneficiary designated by the assignee, any amount of insurance which then becomes payable because of your death will be payable to the assignee. If the assignee is not living, it will be payable to the assignee's estate. In the circumstances described in the two preceding sentences the "Beneficiary Provisions" of the Group Policy do not apply.

Mode of Settlement Provisions.-- You (or your beneficiary if you make no election) may elect payment of the insurance as described in the "About Your Benefits" booklet. Other methods of settlement may be arranged with Prudential. The minimum interest rate for all methods of payment is 2 3/4%. The applicable interest rate will be the rate applied by Prudential to the method of payment selected. Information about the available methods may be obtained from Prudential upon request to IBM.

Conversion Privilege.-- If all or part of an Employee's life insurance ends for one of the reasons stated below, the Employee may convert the insurance which ends to an individual policy of life insurance. Evidence of insurability will not be required. The reasons are:

(1) All of the Employee's insurance ends because: the Employee's employment ends; the Employee transfers out of an eligible class; or all term life insurance of the Group Policy for the Employee's class ends by amendment or because the Group Policy ends.

(2) The Employee's amount of insurance is reduced because of: the end of the Employee's membership in an eligible class; or an amendment to the Group Policy that changes the benefits for the Employee's class; or the Employee's age.

Any conversion for one of the above reasons is subject to the rest of this Section.

Availability.-- The Employee must apply in writing for the individual policy and pay the first premium within 31 days after the Employee's insurance under the Policy ends or the amount of such insurance is reduced.

These are the exceptions to the above rule:

(1) If the Employee has been given written notice of the conversion privilege more than 15 days, but less than 90 days, after the Employee's insurance under the Policy ends or the amount of such insurance is reduced, the Employee must apply for the individual policy and pay the first premium payment by the forty-fifth day after he/she has been given such notice.

(2) If the Employee has not been given notice of the conversion privilege within 90 days after the Employee's insurance under the Policy ends or the amount of such insurance is reduced, the Employee must apply for the individual policy and pay the first premium by the end of such 90 days.

Individual Policy Requirements.-- The individual policy must conform to the following:

Amount: Not more than the following:

(1) If all of the Employee's amount of insurance under the Policy ends, not more than the amount of such insurance when it ends. But, if it ends because all term life insurance of the Group Policy for the Employee's class ends, the total amount will not exceed the total amount of all the Employee's life insurance then ending under the Group Policy reduced by the amount of group life insurance from any carrier for which the Employee is or becomes eligible within the next 45 days.

(2) If the amount of the Employee's insurance under the Policy is reduced, not more than the amount of the reduction.

Form: Any form of a life insurance policy that:

(1) conforms to Title VII of the Civil Rights Act of 1964, as amended, having no distinction based on sex; and

(2) is one that Prudential usually issues at the age and amount applied for.

Subject to the exceptions below, this does not include term insurance or a policy with disability or supplementary benefits.

(continued)

GRP 120602 (16000-1B)

These are the exceptions to the above rule:

(1) The policy may be issued, at the Employee's request, with preliminary term insurance that lasts for one year starting with its effective date.

(2) If the Employee's amount of insurance under the Policy ends due to the Employee's total and permanent disability, the contract may be issued, at the Employee's request, with term insurance without the one-year limit.

Premium: Based on Prudential's rate as it applies to the form and amount, and to the Employee's class of risk and age on its effective date.

Effective Date: The end of the 31 day period during which the Employee may apply for it.

6. IBM Travel Accident Insurance Plan

6.1 Summary

This Plan provides benefits if you are traveling away from your job location or home on company business. Eligibility starts with the first day of your employment. The Plan provides:

- Benefits of up to five times annual compensation for accidental bodily injuries which result in death, dismemberment, loss of sight, hearing, or speech.

6.2 Who is Eligible

Eligible employees are:

- Regular full and part-time employees in travel status on company business and employees on a Personal Leave of Absence Work Option, and supplemental employees who travel on company business.

Eligible family members are:

- your spouse, unmarried children and relatives or others normally residing in your household and principally dependent on you for financial support or physical well-being. Eligible same-gender domestic partners and their children are also covered.

Eligible family members who travel with you with IBM authorization are covered during the period for which their travel or living expenses are reimbursed by IBM (domestic per diems do not constitute reimbursement for dependents). If eligible family members accompany you on an assignment outside the United States, they are covered for the entire period of your assignment.

6.3 What is Covered

Coverage applies to travel on authorized company business (travel for which you are eligible for reimbursement of expenses). It is in effect continuously from the time the business trip actually begins -- whether from your normally assigned job location, home or other location -- until your return home or to your normally assigned job location, whichever occurs first, or when the trip is otherwise terminated. Travel to or from home to your normally assigned job location -- even if followed by a business trip -- does not constitute being in travel status on company business. Also, travel to and from courses eligible for Tuition Refund (or similar reimbursement) is not covered under the Plan.

In addition, coverage is in effect during the period of a temporary assignment requiring a change in residence, during which you receive either travel expense reimbursement or living expense reimbursement or allowance. However, the coverage is not in effect during commutation to or from the assigned job location or while on scheduled vacation.

Coverage is also in effect during the entire period of an assignment outside the United States including travel to and from the location.

In those instances where a trip "outside the building" does not include travel expenses, coverage applies if the journey arises out of and in the course of employment.

Coverage applies to the commute between home and the normally assigned work location (i.e., regular point of reporting to which an employee is permanently assigned) only in the event that management has called the employee into work on a non-scheduled workday or during offshift on a scheduled workday. The normal roundtrip commute between home and the normally assigned work location for the regularly scheduled workday, even with contiguous overtime at management's request, is not covered by the Travel Accident Insurance Plan.

6.3.1 Amount of Coverage

The Travel Accident Insurance Plan provides benefits if you have an accidental bodily injury which results in death (including brain death), dismemberment, or irrecoverable loss of sight, hearing or speech.

This table shows your travel accident insurance coverage. The payable amount is in addition to your IBM Group Life Insurance.

Benefits Payable for:				
Insured person	Loss of life including brain death	Loss of use of one member or sight of one eye *	Loss of use of two or more members or sight (both eyes) or total loss of hearing (both ears) or speech	Loss of hearing one ear
Employee	5 x annual compensation ($50,000 min.)	2 ½ x annual compensation ($25,000 min.)	5 x** annual compensation ($50,000 min.)	2 ½ x annual compensation ($25,000 min., $200,000 max.)
Eligible family member	$50,000	$25,000	$50,000	$25,000
* Includes dismemberment ** This is the maximum benefit for any combination of the above.				

Annual compensation means 12 times your regular monthly salary, plus any current performance bonus target or Annual Executive Incentive. If you are under one of IBM's sales plans, annual compensation is 12 times the monthly on-target earnings (OTE) equivalent. For purposes of this Plan, regular monthly salary does not include any other payments, such as awards and additional compensation resulting from working unusual hours or conditions (for example, nonscheduled workdays, overtime, or a different shift).

The Travel Accident Insurance Plan provides an additional payment of the face value of any personal life insurance, up to $100,000 per individual, when invalidated because of travel on company business.

6.3.2 Aggregate Limit of Liability

The company's limit of liability with respect to all insured persons while in any one accident shall not exceed the below stated aggregate limit of liability:

- $60,000,000 for any aircraft accident
- $100,000,000 for any non-aircraft accident.

If the aggregate amount of all indemnities otherwise payable by reason of coverage provided under this policy exceeds such aggregate limit of liability, the company shall not be liable with respect to each such insured for a greater proportion of the indemnities otherwise payable than the aggregate limit of liability bears to the aggregate amount of all such indemnities.

6.3.3 Travel Accident Insurance Plan Exclusions

This Plan does not cover any loss resulting from sickness, disease, self-inflicted injuries, suicide or any injuries sustained when serving in the armed forces of any country at war, whether declared or not. Also, coverage does not apply while you are on a scheduled vacation, except while you are on an assignment outside of the United States.

6.4 How the Plan Works

6.4.1 Choosing a Beneficiary

You can choose your beneficiary and change your beneficiary at any time by completing the beneficiary designation form (ZM02-6060). Unless otherwise specified on the designation form, your beneficiary will be the same as designated for your IBM Group Life Insurance. If you do not name a beneficiary or if the beneficiary dies first and a new beneficiary is not chosen, payments will be made to your spouse, if living; otherwise, in equal shares to your surviving children or, if none survives, in equal shares to your surviving parents. If no spouse, child or parent is living, payments are made to the executors or administrators of your estate.

It is important to remember that if an employee designates his or her spouse as the beneficiary, and the employee and spouse are later divorced, this former spouse will remain the employee's beneficiary until and unless the employee makes a change. Also remember that if an employee leaves IBM the Travel Accident Insurance benefit is discontinued when employment ceases. If the employee is rehired at a later date, any beneficiary designations from the prior employment period is not valid; a new beneficiary would have to be designated.

6.4.2 Payments to Your Beneficiary

Payments for loss of life are made to beneficiaries as specified above. The beneficiary will be given the choice of receiving the payment in a single amount, in equal monthly installments according to the chart below, or partly in a single amount with the balance in monthly installments. When payments are made in monthly installments, the insurance company credits interest at its current rate per year on the unpaid balance.

This chart shows the installment amount including interest at the rate of 6.5 percent for each $1,000 of insurance. Naturally, interest rates vary and this chart only illustrates the effect of installment payments using a 6.5 percent rate only.

Installment Period	Monthly Installment per $1,000 of Insurance	Installment Period	Monthly Installment per $1,000 of Insurance
1 year	$85.83	5 years	$19.45
2 years	44.31	10 years	11.28
3 years	30.48	15 years	8.65
4 years	23.58	20 years	7.40

If the beneficiary dies before the full amount of insurance is paid out, any balance will be paid to the executors or administrators of the beneficiary's estate unless you or the beneficiary had stipulated some other arrangement. Payments for dismemberment, irrecoverable loss of sight, hearing, speech or loss of use will be made only in a lump sum to the insured individual.

If the beneficiary is a minor, payment will be made to the appointed guardian. If the beneficiary is legally incapable of handling his or her affairs, payment will be made to the responsible entity appointed by the courts.

6.4.3 Conversion Privileges

Coverage under the Travel Accident Insurance Plan ceases when you go on Long-Term Disability, separate or retire from IBM. You can convert a portion or all of the insurance to an individual policy upon payment of the appropriate premium. The converted policy, issued without evidence of insurability, provides indemnity for accidental death and dismemberment only in an amount up to five times annual compensation not to exceed $250,000. To convert your coverage, you must apply to the insurance company within 31 days after you separate, retire or go on Long-Term Disability. A conversion form may be obtained by calling the IBM Employee Services Center (ESC) at 1-800-796-9876. The conversion form, signed by the appropriate IBM representative, will be mailed to your home. For more Information on conversion of your policy, (i.e., rates), please call CIGNA at 1-800-441-1832 (TTY: 1-800-552-5744) and have your completed conversion form available as a reference.

6.5 How to File a Claim

Employees who suffer an accident while traveling on company business should contact their manager.

In the case of the employee's death, the beneficiary will be contacted by IBM and provided with the necessary forms and instructions for filing a claim. In the case of the death of employees' dependents who are covered, employees should initiate the claims procedure by notifying their manager. Upon receipt of the completed forms and documentation, IBM will forward the claim to the insurance carrier for processing and payment. For same-gender domestic partners, a properly executed same-gender domestic partner IBM affidavit will be required for claim processing.

Proof of Loss: Written proof of loss must be furnished to CIGNA in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within ninety days after the termination of the period for which the company is liable and in case of claim for any other loss within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

This is only a summary of the IBM Travel Accident Insurance Plan and highlights the main features of the Plan. When a claim is made, the actual wording of the policy will govern.

7. IBM Long-Term Care Insurance Program

7.1 Summary

This plan describes coverage that went into effect November 1, 1990 through June 1, 2001. Please note: IBM announced the offering of a new Long-Term Care (LTC) Insurance Plan effective July 1, 2001. Please refer to the IBM Long-Term Care Insurance Program (Effective July 1, 2001) for a complete description of this plan.

The IBM Long-Term Care Insurance Program can help protect you from the high cost of long-term care. It allows you choice and flexibility by covering services not only in nursing homes, but in your own home or in an adult day care center as well. The Program also offers respite care benefits that allow unpaid caregivers, such as family members, a chance to take time off from caregiving responsibilities.

The IBM Long-Term Care Insurance Program was specifically developed for IBM by John Hancock Life Insurance Company.

7.2 Who is Eligible

The following people are eligible to apply for the IBM Long-Term Care Insurance Program:

- Regular full-and part-time employees who are actively at work
- Spouses, surviving spouses and qualified domestic partners (age 18 and over) of eligible employees
- Parents of eligible employees and parents of eligible employees' spouses and qualified domestic partners

7.3 What is Covered

7.3.1 Levels of Care Covered

The IBM Long-Term Care Insurance Program allows you to receive the appropriate level of care, whether skilled, intermediate or custodial, and to choose the site of care that is best for you. The following services are covered:

Nursing home care: Services provided by a licensed skilled, intermediate, or custodial nursing facility.

Home health care: Services provided in your home by registered nurses, licensed practical nurses, licensed therapists, and home health aides working through a licensed home health agency.

Adult day care: Services provided through approved adult day care centers which offer physical care in addition to educational and social activities.

Respite care: Services which are designed to give temporary relief to unpaid caregivers. Respite care can be provided by professionals or non-professionals.

7.3.2 Relationship to Other IBM Plans

The IBM Medical Plan offers protection for acute medical care and provide for reimbursement of certain home health services when incurred as an extension of, or alternative to, professional services provided in a general hospital or skilled nursing facility. However, custodial care is not covered under the IBM Medical Plan.

7.4 How the Plan Works

7.4.1 Enrollment

Enrollments will be processed by John Hancock on an ongoing basis with evidence of insurability. The effective date of long-term care insurance coverage is the first month following the month the application is approved, although certain circumstances may cause a delay in the effective date of coverage.

New hires who apply within 90 days of their date of hire are guaranteed acceptance without completing the Statement of Health. All other applicants must complete Statement of Health and be approved for coverage by John Hancock.

7.4.2 Benefit Options

Three options are available. You select the option that best fits your needs.

	Option 1	Option 2	Option 3
Daily Maximum Benefit	$65	$135	$200
Maximum Lifetime Benefit	$120,000	$250,000	$365,000

The IBM Long-Term Care Insurance Program will pay the actual daily charges for services received up to your selected daily maximum. One hundred percent of the daily maximum benefit applies to nursing home services and 50 percent to home health care, adult day care, and respite care. For example, under Option 2 you will receive up to $135 per day if you are in a nursing home and up to $67.50 if you are receiving home health care or adult day care, which are typically less expensive than nursing home services.

7.4.3 Premium Payments

The amount of your premium will depend upon the coverage option you select and your age at enrollment. The younger you are when you apply for this coverage, the lower your premium will be.

The following are some examples of current monthly premiums, effective October 1, 1999:

Ages	Daily Maximum Benefit Options		
	$65.00	$135.00	$200.00
30	6.45	11.35	15.90
40	13.01	23.51	33.26
50	20.62	39.66	57.34
60	39.75	80.07	117.51

Please refer to the IBM Long-Term Care Insurance Program Appendix for a complete list of premium amounts.

Your premium contribution will not be increased because of age, illness, or how often you receive benefits, nor can coverage be canceled for these reasons. However, the cost of this coverage may be adjusted based on overall program experience over a period of years, in which case the premium will be adjusted for everyone in the same class or group.

Employees and individuals on the IBM Medical Disability Income Plan may elect to have their premiums (and their spouse's or domestic partner's premiums) deducted from their paycheck or disability income payment via monthly payroll deduction, or be billed directly. All other covered individuals will be billed directly by John Hancock.

7.4.4 Inflation Adjustment

The Plan offers an inflation adjustment feature. Every three years the costs for nursing home and other eligible services will be reviewed. If the costs increase due to inflation, you may be offered the opportunity to increase your maximum daily amount. The additional cost for the increase will be based on your age at the time of the new offering. You may choose to accept the increased level of coverage as long as you have not incurred charges for which benefits are payable within six months prior to the date of the offer and your attained age is less than 85 on the date of the offer.

7.4.5 Qualifying for Benefits

You will qualify for benefits if you are certified as being unable to perform independently at least two of the following five Activities of Daily Living (ADL):

- Bathing or dressing
- Eating
- Toileting
- Transferring from bed to chair
- Maintaining continence

and you have completed the waiting period as defined below and are incurring covered expenses for nursing home care, home health care or adult day care. You do not need to have been hospitalized or to have undergone medical treatment to qualify for benefits under this program.

Pre-existing condition: You will need to satisfy a waiting period of six months from your effective date of coverage if you have a pre-existing condition. This is a condition for which medical advice or treatment was recommended or received during the six months prior to your effective date of coverage. You must satisfy this waiting period, if applicable, before you may be certified for benefits.

7.4.6 Receiving Benefits

Benefit payments begin after a waiting period of 120 days from certification of your Activities of Daily Living (ADL) dependency during which you have continuously incurred expenses for covered services. The waiting period begins on the date you are certified for benefits and incur a covered expense for nursing home care, home health care or adult day care.

After you have completed the waiting period, and as long as you are incurring covered expenses for nursing home care, home health care or adult day care, your premium will be waived.

Premium payments will resume only when you do not incur covered expenses for nursing home care, home health care or adult day care during a calendar month.

See "How to File a Claim" for other information on receiving benefits payments under the program.

7.4.7 Loss of Eligibility

If an event occurs that makes you ineligible to participate under the policy -- for example, the spouse of a retiree purchases coverage and is later divorced -- you may maintain your coverage, although not necessarily at the same premium. Further information about continuation and conversion options will be sent to you once you are enrolled in the program.

7.4.8 Nonforfeiture Provision

If you have paid premiums for 10 consecutive years and you discontinue premium payments, you will retain coverage of 30 percent of your original Daily Maximum Benefit. (Calculation of consecutive years does not include periods of premium waiver.) For each year beyond the 10th year that you continue to pay premiums, the amount of your reduced coverage will increase by 3 percent, up to a maximum reduced coverage of 75 percent of your Daily Maximum Benefit.

Note: The nonforfeiture provision may be changed or deleted to satisfy requirements of state insurance departments.

7.5 How to File a Claim

Certification of Activities of Daily Living (ADL) Dependency: If you believe you may qualify to receive benefits under this program, you should contact John Hancock immediately by calling 1-800-255-8991 (TTY: 1-800-255-1808). You will be asked to complete a Certification of Need Form, which allows a John Hancock case manager to assess your level of ADL dependency. If you are determined to be dependent in two ADLs, your Date of Certification will be established.

Completing the Waiting Period: The waiting period is completed after you have been credited for 120 days of covered services, beginning no sooner than your Date of Certification as established above. Incurring an expense for a covered service other than respite care on at least one day out of a calendar week credits you for seven days toward the 120 day waiting period. If the waiting period is not completed within 18 months after the date it begins, then a new waiting period will begin and must be completed before benefits are payable.

Filing for Benefits Payments: Toward the end of your waiting period, John Hancock will notify you as to the date you can begin receiving benefits payments. A supply of claims forms will be sent to you. Benefits can either be paid to the insured person or to the covered provider of service.

7.6 Rights if Your Claim is Denied

If your claim for benefits under the policy is denied in whole or in part, you or your authorized representative will receive a written notice giving the reason for the denial. You will then be entitled to a review of that claim denial if (1) you make a written request for such review; and (2) you send such request to John Hancock within 60 days after receipt of the denial. When

requesting a review, please state the reasons you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate.

John Hancock will then review and make a final decision with respect to the claim appeal for benefits under the policy. This decision will be in writing, and, if a denial, will include specific reasons for the denial. The decision will be made promptly, and usually not later than 60 days after John Hancock receives the request for review.

7.7 ERISA Information

Name of the Plan	The IBM Long-Term Care Insurance Program
Name and Address of Employer Maintaining the Plan	IBM Corporation New Orchard Road Armonk, NY 10504
Employer Identification Number	13-0871985
Plan Number	526
Type of Plan	Employee Welfare Plan including: Long-Term Care Benefits
Claims Administrator and ERISA Claim Reviewer	John Hancock Life Insurance Company Group Long-Term Care Division 529 Main Street X-3 Boston, MA 02129
Plan Administrator's Business Address and Telephone Number	Office of the Plan IBM Employee Services Center 3808 Six Forks Road Raleigh, NC 27609 Telephone: (800) 796-9876

7.7.1 Agent for Service of Legal Process

Service of legal process in disputes arising under the provisions of the insurance contract may be made upon John Hancock Life Insurance Company, Attention: Group Long-Term Care Division, 529 Main Street X-3, Boston, MA 02129.

For disputes arising under the Plan, legal process may be directed to the Plan Administrator at the Plan Administrator's address in the previous table.

7.7.2 Fiduciaries

With respect to benefits under the Plan, the named fiduciaries of the Plan, within the meaning of Section 402(a) of ERISA, with authority to control and manage the operation of the Plan, are as follows:

Named Fiduciary	Area of Fiduciary Responsibility
John Hancock	Provision of full and fair review of claim denials pursuant to Section 503 of ERISA
Plan Administrator	All other areas not included above

Each named fiduciary may appoint a person or persons other than a named fiduciary to carry out the fiduciary responsibilities of the named fiduciary under the Plan.

The fiduciary responsibilities of the named fiduciaries shall be exercisable severally and not jointly, and each named fiduciary's responsibilities will be limited to the specific areas indicated for such named fiduciary.

7.7.3 Discretionary Authority of Plan Administrator and other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

7.7.4 Plan Year

The Plan's fiscal records are kept on a policy year beginning each January 1st and ending on the following December 31st.

7.7.5 Customer Service

You may obtain additional information from John Hancock by calling 1-800-255-8991 (TTY: 1-800-255-1808). A complete enrollment kit including a brochure and enrollment forms is available from John Hancock or on-line through the IBM You and IBM Web site.

This is only a summary of the IBM Long-Term Care Insurance Program and does not cover all the details. A complete statement of the governing terms and conditions of your insurance coverage can be found in the group insurance certificate that will be issued to you if you become insured.

7.8 IBM Long-Term Care Insurance Program Appendix

Inflation-Adjusted Monthly Premiums

Issue Age*	Your monthly premium will be		
	Option 1 ($65)	Option 2 ($135)	Option 3 ($200)
20 and under	2.37	4.05	5.61
21	2.70	4.38	5.94
22	2.81	4.77	6.59
23	3.20	5.30	7.25
24	3.54	5.92	8.13
25	3.97	6.63	9.10
26	4.32	7.40	10.26
27	4.77	8.27	11.52
28	5.29	9.21	12.85
29	5.88	10.22	14.25
30	6.45	11.35	15.90
31	7.05	12.51	17.58
32	7.68	13.70	19.29
33	8.34	14.92	21.03
34	8.97	16.25	23.01
35	9.65	17.49	24.77
36	10.30	18.84	26.77
37	11.10	19.92	28.11
38	11.75	21.13	29.84
39	12.38	22.32	31.55
40	13.01	23.51	33.26
41	13.89	25.23	35.76
42	14.65	26.83	38.14
43	15.37	28.25	40.21
44	16.09	29.67	42.28
45	16.75	31.17	44.56
46	17.45	32.57	46.61
47	18.15	34.11	48.93
48	18.89	35.83	51.56
49	19.71	37.63	54.27
50	20.62	39.66	57.34
51	21.65	41.81	60.53
52	22.80	44.36	64.38
53	24.12	47.22	68.67
54	25.63	50.55	73.69
55	27.35	54.09	78.92
56	29.27	58.25	85.16
57	31.45	62.81	91.93
58	33.94	67.96	99.55
59	36.71	73.67	107.99
60	39.75	80.07	117.51
61	43.21	87.03	127.72

Issue Age*	Your monthly premium will be		
	Option 1 ($65)	Option 2 ($135)	Option 3 ($200)
62	47.00	94.74	139.07
63	51.11	103.19	151.55
64	55.75	112.45	165.10
65	60.69	122.57	180.03
66	66.15	133.49	196.02
67	72.09	145.45	213.57
68	80.08	161.98	238.03
69	88.02	178.46	262.44
70	95.94	194.92	286.83
71	103.83	211.21	310.92
72	111.74	227.66	335.30
73	120.78	246.36	362.97
74	132.06	269.54	397.20
75	145.27	297.03	437.95
76	160.45	328.45	484.45
77	177.42	363.48	536.25
78	190.07	389.71	575.09
79	202.58	415.66	613.52
78	215.02	441.26	651.34
79	103.83	211.21	310.92
80	111.74	227.66	335.30
81	227.19	466.59	688.89
82	239.28	491.56	725.82
83	251.25	516.27	762.36
84	263.06	540.68	798.47
85	274.70	564.78	834.14
86	286.17	588.57	869.37
87	297.55	612.13	904.24
88	308.82	635.30	938.46
89	319.87	658.25	972.46
90	330.86	680.86	1,005.86
91	341.66	703.28	1,039.07
92	352.33	725.29	1,071.61
93	362.87	747.03	1,103.75
94	373.29	768.51	1,135.50
95+	393.72	810.64	1,197.78

* Your issue age is your age on your birthday closest to the date John Hancock receives your application.
** Slightly higher rates may apply in some states because of requirements imposed by those particular states. Contact John Hancock for further information.

8. IBM Long-Term Care Insurance Program (Effective July 1, 2001)

8.1 Summary

IBM announced the offering of a new Long-Term Care (LTC) Insurance Plan effective July 1, 2001. Individuals who are enrolled in the prior LTC plan have the choice of either applying for the new plan or continuing coverage under the prior plan. Individuals who had coverage in the prior LTC plan will not automatically convert to the new LTC plan.

The IBM Long-Term Care Insurance Program was designed to cover a wide range of long-term care services including care provided in nursing homes, alternate care facilities, your home, adult day care centers as well as informal care, hospice care, and respite care.

The IBM Long-Term Care Insurance Program was specifically developed for IBM by John Hancock Life Insurance Company, Boston, MA 02117.

Notice: This is only a summary of the IBM Long-Term Care Insurance Plan; it does not cover all of the details. The Certificate of Insurance that is issued to you when you become approved for coverage contains a more detailed statement of the terms and conditions of your insurance coverage.

8.2 Who Is Eligible

The following people are eligible to apply for the IBM Long-Term Care Insurance Program:

- Regular full-and part-time employees who are actively at work
- Spouses, surviving spouses and qualified domestic partners (age 18 and over) of eligible employees
- Parents of eligible employees and parents of eligible employees' spouses and qualified domestic partners

8.3 What Services are Covered

Nursing Home Care

Includes skilled, intermediate, or custodial care in a qualified nursing facility either Medicare-certified or licensed by the state to provide skilled or intermediate care. Includes physical, respiratory, occupational, or speech therapy.

Alternate Care Facility

Includes care received in assisted living facilities, Alzheimer's facilities, custodial care facilities, or other alternatives to a qualified nursing facility that meet specified policy qualifications.

Home Health Care*

Includes home nursing care provided by a registered nurse, licensed practical nurse, or licensed vocational nurse; physical, respiratory, occupational, or speech therapy provided by licensed therapists; nutritional counseling provided or supervised by a qualified home health agency and custodial support services provided by a qualified home health aide.

Adult Day Care*

Includes a wide range of medical and social support services, provided by a qualified adult day care center that has a planned program of services at least five days a week for at least six hours a day and meets the specified policy qualifications.

* Home health and adult day care services are covered when they are part of a physician's plan of care or approved by a John Hancock patient advocate and when performed by a person who does not ordinarily live with you.

Custodial Care

Can take place in a variety of settings and the site determines the percentage of the daily maximum benefit that is reimbursed. This type of care includes assistance in activities of daily living, such as dressing, eating, bathing, administering medication, and preparing special diets. It may be provided by a person without professional skills or training but must be ordered by a physician.

Informal Care

Includes assistance with the activities of daily living, supervision for the protection of an insured who is cognitively impaired, and maintenance of the home environment (i.e., shopping, menu planning, meal preparation, and light housekeeping). Informal care can be provided by a person without professional skills or training including family members, whether or not that person ordinarily resides in your home. Informal care benefit can be paid in addition to the home health care/adult day care benefit.

Hospice Care

Covered at home if the services meet John Hancock's definition of home health care. Inpatient hospice care is covered in a nursing home or alternate care facility if these facilities meet John Hancock's definitions.

Respite Care

Services which are designed to give temporary relief to unpaid caregivers. Respite care can be provided by professionals or non-professionals. Care received in a respite situation is covered the same as care received in a non-respite situation.

8.4 What Additional Features are Included?

Return of Premium at Death Benefit

A Return of Premium at Death Benefit is included in your coverage. This benefit will pay to your estate a portion of the premiums you paid, less any benefits paid or payable, should you die prior to age 70 while covered under the plan. The portion of the premium is based on your age at the time of death as shown below (this benefit is not available to residents of Arkansas or Washington):

Age	Percentage of Premium
65 and under	100%
66	80%
67	60%
68	40%
69	20%
70	0%

There is no return of premium if you are age 70 or older or if coverage is in reduced paid-up status.

Portability

If you retire or leave IBM, your coverage may be continued at the same premium rate as that paid by active employees. You will pay premiums through pension deduction or directly to John Hancock.

Bed Reservation Benefit

A temporary bed reservation benefit will be paid to hold a bed in a nursing home or alternate care facility for up to 14 days if an insured is receiving benefits for care in a nursing home or alternate care facility and is hospitalized on a short-term basis.

Initial Care Planning Visit

This feature is a face-to-face visit offered to you when you become certified for benefits at the beginning of the Qualification Period. At your option, a local case manager, selected by John Hancock and at Hancock's expense, visits you to assess the need for health care and related services and to assist you and your family in developing a comprehensive care plan.

8.5 How the Plan Works

8.5.1 Enrollment

Enrollments will be processed by John Hancock on an ongoing basis with evidence of insurability. The effective date of long-term care insurance coverage is the first month following the month the application is approved, although certain circumstances may cause a delay in the effective date of coverage. New hires who apply within 90 days of their date of hire are guaranteed acceptance without completing the Statement of Health. All other applicants must complete a Statement of Health and be approved for coverage by John Hancock.

To apply, visit the IBM Long-Term Care website at: http//ibm.jhancock.com or you may request an application by calling John Hancock's customer service unit at 1-800-255-8991; TTY: 1-800-255-1808.

8.5.2 Levels of Coverage

When you apply for coverage, you will choose your Daily Maximum Benefit (DMB) from the options listed below. The DMB is the most the insurance may pay for all covered services received on any day. Each option has a corresponding Lifetime Maximum Benefit (LMB). The LMB is the most the insurance will pay for all covered services received while insured.

DMB	NURSING HOME	ALTERNATE CARE	HOME HEALTH/ ADULT DAY CARE	INFORMAL CARE*	LIFETIME MAX
$115	$115	$86.25	$69.00	$28.75	$210,000
$175	$175	$131.25	$105.00	$43.75	$320,000
$260	$260	$195.00	$156.00	$65.00	$475,000
$345	$345	$258.75	$207.00	$86.25	$630,000

*** The total benefits payable for all informal care received in any calendar year is 30 times the informal care DMB.**

8.5.3 Reduced Paid-up Benefit (Nonforfeiture Benefit)

In addition to choosing your DMB level, you have the choice of including a Reduced Paid-up Benefit (Non-forfeiture Benefit) in your coverage for an additional cost. The Reduced Paid -Up Benefit will allow you to stop making premium payments after paying premiums for at least three years and retain a reduced level of coverage. If you exercise this benefit, you will keep your full DMB amount, but the Lifetime Maximum Benefit (LMB) amount will be reduced. Your reduced LMB will equal the greater of 30 times your nursing home DMB or the sum of premiums paid.

8.5.4 Premium Payments

The amount of your premium will depend upon the coverage option you select and your age at enrollment. The younger you are when you apply for this coverage, the lower your premium will be.

Once you are enrolled, your premiums cannot be increased because of your age, illness, or how often you use benefits. Your premium will be adjusted only if premiums are adjusted for an entire group or class. Rates for this plan are guaranteed not to change before June 30, 2006 unless you have a change in coverage.

Please refer to the IBM Long-Term Care insurance monthly premium rates attached for a list of premium amounts. Rates will vary for residents of Connecticut, Delaware, Kansas, Washington and Arkansas. Residents of these states may call the John Hancock Long-Term Care Customer Service Center at 1-800-255-8991 (TTY: 1-800-255-1808) for a rate quote.

8.5.5 Inflation Adjustment

You will be offered additional amounts of coverage every three years to keep up with inflation. The amount of each adjustment will reflect a benefit increase of at least 5% compounded annually for the applicable period. An inflation adjustment will not be available if you are issue age 85 or older, or you have been certified for benefits in the six months prior to the increase effective date, or if coverage is in reduced paid-up status. The premium for the amount of coverage increase will be based on your age on your birthday closest to the effective date of the increase. The premium for your existing coverage will not change because of your election.

8.5.6 Qualifying for Benefits

You will qualify for benefits when a John Hancock patient advocate certifies that, due to a covered condition, you are dependent in at least two of six Significant Activities of Daily Living

(SADLs), or you are cognitively impaired, and you have completed the Qualification Period as described below

You are dependent in a SADL if you need substantial assistance from another person to perform a SADL due to loss of functional capacity that is expected to continue for at least 90 days. The six SADLs are:

- Bathing
- Dressing
- Eating
- Maintaining continence
- Toileting
- Transferring from bed to chair

Qualification Period

The qualification period (waiting period) is the period of time you must wait from the date you are certified for benefits until the date benefits are payable for covered charges you incur. The Qualification Period is 90 days. You must remain certified during this period, but you do not have to receive long-term care services or be hospitalized.

8.6 How to File a Claim

If you believe you may qualify to receive benefits under this program, you should contact John Hancock immediately by calling 1-800-255-8991 (TTY: 1-800-255-1808).

You will be asked to complete a Certification of Need Form, which allows a John Hancock patient advocate to assess your dependency. If you are determined to meet the criteria you will be certified at that time.

8.7 Waiver of Premium

Your premium payments will be waived once you are certified for benefits, complete the Qualification Period, and incur at least 30 days of covered expenses for services other than informal care. The waiver will continue as long as you remain certified.

Coordination of Benefits

To prevent duplication of benefits, the Long-Term Care Insurance Policy coordinates benefits with group plans providing coverage for long-term care expenses. Coordination of benefits is a common feature of most group health care insurance plans. The plan considered "primary" pays first. The secondary plan then makes up the difference of the actual amount up to the total allowable expense. The rules determining which plan pays benefits first will be described in detail in the certificate you receive if you become approved for coverage.

If the policy is secondary to Medicare, the insurance will not pay benefits for any charge to the extent that a benefit is payable for that charge under Medicare, or would be payable under Medicare but for the deductible and coinsurance provisions of Medicare.

EXCLUSIONS:

- Mental or emotional disorders without demonstrable organic disease. This includes but is not limited to: neurosis, psycho-neurosis, psychopathy, and psychosis. This exclusion does not apply to Alzheimer's disease and other organically caused brain disorders
- Intentionally self-inflicted injury
- Home health care or adult day care provided by a member of the insured's family who ordinarily resides in the insured's home
- Conditions caused by committing or attempting to commit a felony, or participating in a riot or insurrection
- Care specifically provided for detoxification of or rehabilitation for alcoholism or drug abuse
- Conditions caused by war, or any act of war, whether declared or not, or service in the armed forces or auxiliary units
- Care or treatment provided outside the United States and its possessions
- A service or supply furnished by or covered as a benefit under a program of any government or its subdivisions or agencies, except as otherwise required by law and except: a program established by the federal government for its civilian employees, Medicare, and Medicaid (any state medical assistance program under Title XIX of the Social Security Act as amended from time to time)
- A service or supply for which a charge would not have been made in the absence of insurance

No benefit will be payable under the policy for any charge to the extent that a benefit is payable for that charge under Medicare or would be payable under Medicare but for the coinsurance and deductible provisions of Medicare.

These exclusions may not apply in all states and may vary depending on the state in which you live. The Certificate of Insurance you receive once you are approved for coverage will outline the exact exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance was originally delivered to you will apply.

Long-term care providers must meet the qualifications specified in the Certificate of Insurance that will be issued to you when you become approved for coverage, and services and supplies must be provided in accordance with a plan of care prescribed by a licensed health care practitioner.

8.8 Rights If Your Claim Is Denied

If your claim for benefits under the policy is denied in whole or in part you or your authorized representative will receive a written notice giving the reason for the denial. You will then be entitled to a review of that claim denial if (1) you make a written request for such review; and (2) you send such request to John Hancock within 60 days after receipt of the denial. When requesting a review, please state the reasons you believe the claim was improperly denied and submit any data, questions or comments you deem appropriate.

John Hancock will then review and make a final decision with respect to the claim appeal for benefits under the policy. This decision will be in writing, and, if a denial, will include specific reasons for the denial. The decision will be made promptly, and usually not later than 60 days after John Hancock receives the request for review.

8.9 ERISA Information

Name of the Plan Program:	The IBM Long-Term Care Insurance
Name and Address of Employer Maintaining the Plan:	IBM Corporation New Orchard Road Armonk, NY 10504
Employer Identification Number:	13-0871985
Plan Number:	526
Play Type:	Employee Welfare Plan including Long-Term Care Benefits
Claim Administrator and ERISA Claim Reviewer:	John Hancock Life Insurance Company Group Long-Term Care Division 529 Main Street X-3 Boston, MA 02129
Plan Administrator's Business Address and Telephone Number:	Office of the Plan Administrator IBM Employee Services Center 3808 Six Forks Road Raleigh, NC 27609 Telephone: (800) 796-9876

8.9.1 Agent for Service of Legal Process

Service of legal process in disputes arising under the provisions of the insurance contract may be made upon John Hancock Life Insurance Company, Attention: Group Long-Term Care Division, 529 Main Street X-3, Boston, Massachusetts 02129. For disputes arising under the Plan, legal process may be directed to the Plan Administrator at the Plan Administrator's address in the previous table.

8.9.2 Fiduciaries

With respect to benefits under the Plan, the named fiduciaries of the Plan, within the meaning of Section 402(a) of ERISA, with authority to control and manage the operation of the Plan, are as follows:

Named Fiduciary	Area of Fiduciary Responsibility
John Hancock	Provision of full and fair review of claim denials pursuant to Section 503 of ERISA
Plan Administrator	All other areas not included above

Each named fiduciary may appoint a person or persons other than a named fiduciary to carry out the fiduciary responsibilities of the named fiduciary under the Plan.

The fiduciary responsibilities of the named fiduciaries shall be exercisable severally and not jointly, and each named fiduciary's responsibilities will be limited to the specific areas indicated for such fiduciary.

8.9.3 Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the

Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

8.9.4 Plan Year

The Plan's fiscal records are kept on a policy year beginning each January 1st and ending on the following December 31st.

8.9.5 Customer Service

If you have any questions regarding the IBM Long-Term Care Insurance Plan you may call the John Hancock Long-Term Care Customer Service Center at 1-800-255-8991 (TTY: 1-800-255-1808). If you are outside of the United States, call 1-617-886-8713. Or you may visit the Web site at http://ibm.jhancock.com

8.10 IBM GROUP LONG-TERM CARE INSURANCE MONTHLY PREMIUM RATES WITH REDUCED PAID-UP BENEFIT

	Daily Maximum Benefit Options			
Issue Age*	**$115 DMB**	**$175 DMB**	**$260 DMB**	**$345 DMB**
20 or younger	$8.70	$13.23	$19.66	$26.09
21	$9.08	$13.81	$20.52	$27.23
22	$9.47	$14.41	$21.41	$28.41
23	$9.88	$15.04	$22.34	$29.65
24	$10.31	$15.69	$23.31	$30.93
25	$10.76	$16.37	$24.33	$32.28
26	$11.23	$17.09	$25.38	$33.68
27	$11.72	$17.83	$26.49	$35.15
28	$12.23	$18.60	$27.64	$36.68
29	$12.76	$19.41	$28.84	$38.27
30	$13.31	$20.26	$30.10	$39.94
31	$13.95	$21.23	$31.55	$41.86
32	$14.62	$22.25	$33.06	$43.87
33	$15.33	$23.33	$34.65	$45.98
34	$16.07	$24.45	$36.32	$48.20
35	$16.84	$25.62	$38.07	$50.52
36	$17.65	$26.86	$39.90	$52.95
37	$18.50	$28.15	$41.82	$55.50
38	$19.39	$29.50	$43.84	$58.17
39	$20.32	$30.92	$45.94	$60.96
40	$21.30	$32.41	$48.16	$63.90
41	$22.79	$34.68	$51.52	$68.37
42	$24.38	$37.10	$55.12	$73.15
43	$26.09	$39.70	$58.98	$78.26
44	$27.91	$42.47	$63.10	$83.73
45	$29.86	$45.44	$67.51	$89.58
46	$31.95	$48.62	$72.23	$95.85
47	$33.99	$51.72	$76.84	$101.96
48	$36.16	$55.02	$81.74	$108.47
49	$38.46	$58.53	$86.96	$115.39
50	$40.92	$62.26	$92.50	$122.75
51	$43.53	$66.23	$98.40	$130.58
52	$46.30	$70.46	$104.68	$138.91
53	$49.26	$74.95	$111.36	$147.77
54	$52.45	$79.81	$118.58	$157.35
55	$55.85	$84.99	$126.27	$167.55
56	$59.47	$90.50	$134.46	$178.42
57	$63.33	$96.37	$143.18	$189.99
58	$67.44	$102.62	$152.47	$202.31
59	$71.81	$109.28	$162.36	$215.43

Daily Maximum Benefit Options				
Issue Age*	**$115 DMB**	**$175 DMB**	**$260 DMB**	**$345 DMB**
60	$76.47	$116.37	$172.89	$229.41
61	$81.17	$123.51	$183.50	$243.50
62	$86.15	$131.10	$194.77	$258.45
63	$91.44	$139.15	$206.74	$274.32
64	$97.06	$147.70	$219.43	$291.17
65	$103.02	$156.77	$232.91	$309.06
66	$109.35	$166.40	$247.22	$328.04
67	$118.50	$180.33	$267.92	$355.51
68	$128.43	$195.44	$290.36	$385.29
69	$139.18	$211.80	$314.68	$417.55
70	$150.84	$229.54	$341.03	$452.53
71	$163.47	$248.77	$369.60	$490.42
72	$177.17	$269.60	$400.55	$531.50
73	$192.00	$292.18	$434.10	$576.01
74	$209.07	$318.15	$472.67	$627.20
75	$227.65	$346.42	$514.68	$682.94
76	$247.88	$377.20	$560.42	$743.63
77	$269.90	$410.72	$610.22	$809.71
78	$293.89	$447.22	$664.45	$881.67
79	$320.01	$486.97	$723.49	$960.02
80	$345.82	$526.25	$781.85	$1,037.46
81	$373.71	$568.69	$844.91	$1,121.14
82	$403.86	$614.56	$913.07	$1,211.57
83	$436.43	$664.13	$986.71	$1,309.29
84	$471.63	$717.70	$1,066.30	$1,414.90
85	$509.68	$775.59	$1,152.31	$1,529.03
86	$550.79	$838.15	$1,245.25	$1,652.36
87	$595.21	$905.76	$1,345.70	$1,785.64
88	$666.64	$1,014.45	$1,507.18	$1,999.91
89	$746.63	$1,136.18	$1,688.04	$2,239.90
90 and over	$1,007.96	$1,533.85	$2,278.86	$3,023.87

** Issue age is your age on your birthday closest to the date John Hancock receives your application.*

8.11 IBM GROUP LONG-TERM CARE INSURANCE MONTHLY PREMIUM RATES WITHOUT REDUCED PAID-UP BENEFIT

Daily Maximum Benefit Options				
Issue Age*	**$115 DMB**	**$175 DMB**	**$260 DMB**	**$345 DMB**
20 or younger	$7.50	$11.41	$16.95	$22.49
21	$7.82	$11.91	$17.69	$23.47
22	$8.16	$12.42	$18.46	$24.49
23	$8.52	$12.96	$19.26	$25.56
24	$8.89	$13.53	$20.10	$26.67
25	$9.28	$14.12	$20.97	$27.83
26	$9.68	$14.73	$21.88	$29.04
27	$10.10	$15.37	$22.84	$30.30
28	$10.54	$16.04	$23.83	$31.62
29	$11.00	$16.74	$24.86	$32.99
30	$11.48	$17.46	$25.95	$34.43
31	$12.03	$18.30	$27.19	$36.08
32	$12.61	$19.18	$28.50	$37.82
33	$13.21	$20.11	$29.87	$39.64
34	$13.85	$21.08	$31.31	$41.55
35	$14.52	$22.09	$32.82	$43.55
36	$15.21	$23.15	$34.40	$45.64
37	$15.95	$24.27	$36.05	$47.84
38	$16.71	$25.43	$37.79	$50.14
39	$17.52	$26.66	$39.61	$52.56
40	$18.36	$27.94	$41.51	$55.08
41	$19.65	$29.90	$44.42	$58.94
42	$21.02	$31.99	$47.52	$63.06
43	$22.49	$34.22	$50.84	$67.46
44	$24.06	$36.61	$54.40	$72.18
45	$25.74	$39.17	$58.20	$77.23
46	$27.54	$41.91	$62.27	$82.63
47	$29.30	$44.59	$66.24	$87.90
48	$31.17	$47.43	$70.47	$93.51
49	$33.16	$50.46	$74.96	$99.47
50	$35.27	$53.67	$79.75	$105.82
51	$37.52	$57.10	$84.83	$112.57
52	$39.92	$60.74	$90.24	$119.75
53	$42.46	$64.62	$96.00	$127.38
54	$45.22	$68.81	$102.23	$135.65
55	$48.15	$73.27	$108.86	$144.44
56	$51.27	$78.02	$115.92	$153.81
57	$54.60	$83.08	$123.43	$163.79
58	$58.14	$88.47	$131.44	$174.41
59	$61.91	$94.21	$139.96	$185.72
60	$65.92	$100.31	$149.04	$197.76
61	$69.97	$106.48	$158.19	$209.91
62	$74.27	$113.02	$167.91	$222.80
63	$78.83	$119.96	$178.22	$236.49
64	$83.67	$127.32	$189.17	$251.01
65	$88.81	$135.14	$200.79	$266.43

Daily Maximum Benefit Options				
Issue Age*	**$115 DMB**	**$175 DMB**	**$260 DMB**	**$345 DMB**
66	$94.26	$143.45	$213.12	$282.79
67	$102.16	$155.46	$230.97	$306.48
68	$110.71	$168.48	$250.31	$332.14
69	$119.99	$182.59	$271.27	$359.96
70	$130.04	$197.88	$293.99	$390.11
71	$140.93	$214.45	$318.62	$422.78
72	$152.73	$232.41	$345.30	$458.19
73	$165.52	$251.88	$374.22	$496.56
74	$180.23	$274.26	$407.48	$540.69
75	$196.25	$298.64	$443.69	$588.74
76	$213.69	$325.17	$483.12	$641.06
77	$232.68	$354.07	$526.05	$698.03
78	$253.35	$385.54	$572.80	$760.06
79	$275.87	$419.80	$623.70	$827.60
80	$298.12	$453.66	$674.01	$894.36
81	$322.17	$490.25	$728.37	$966.50
82	$348.15	$529.80	$787.13	$1,044.45
83	$376.23	$572.53	$850.61	$1,128.70
84	$406.58	$618.71	$919.23	$1,219.74
85	$439.38	$668.61	$993.37	$1,318.13
86	$474.82	$722.55	$1,073.50	$1,424.45
87	$513.11	$780.83	$1,160.08	$1,539.34
88	$574.69	$874.53	$1,299.29	$1,724.06
89	$643.65	$979.47	$1,455.21	$1,930.95
90 and over	$868.93	$1,322.28	$1,964.53	$2,606.78

** Issue age is your age on your birthday closest to the date John Hancock receives your application.*

9. Employee Retirement Income Security Act

9.1 ERISA Requirements

On September 2, 1974, the Employee Retirement Income Security Act of 1974 (often referred to as ERISA) was enacted, establishing federal controls over most employee pension and welfare benefit plans. The plans covered in this book which are governed by ERISA have been established by IBM Corporation, New Orchard Road Armonk, NY, Employer Identification Number 13-0871985. The Plan Administrator is the Manager of U.S. Benefits Services, IBM Human Resources. The address for the Plan Administrator is: Office of the Plan Administrator, IBM Employee Services Center, 3808 Six Forks Road, Raleigh, NC, 27609; telephone (800) 796-9876. Service of legal process may be made upon the Plan Administrator.

The records of all of the plans covered in this book which are governed by ERISA are kept on a calendar year basis, beginning January 1st and ending December 31st of each year, which is in each case, the plan year.

As a participant in the plans covered in this book which are governed by ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all plan documents, including insurance contracts and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report for plans that are required to have such report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans covered in this book which are governed by ERISA. The people who operate your plans, called "fiduciaries" of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

It is anticipated that most questions can be answered by the IBM Employee Services Center at 1-800-796-9876 (TTY: 1-800-426-6537), outside U.S. call (919) 784-8646.

ERISA provisions require that all employees have the following Information:

Table 1. ERISA Information

Plan Name and Number	IBM Long-Term Care Insurance Program (526)	IBM Long-Term Disability Plan (525)	IBM Medical Disability Income Plan (506) IBM Regular Part-Time Employee Medical Disability Income Plan (515)s
Plan Type	Long-term care	Long-term disability	Long-term disability
Administration	Contract administration insurer	Insurance policy and contract administration	Plan Administrator
Funding	IBM financial assistance for employee premiums	Insurance premium and claim experience and administrative fee	IBM contribution based on actuarial determination or payment from operating funds
Plan Trustee(s), Insurer(s) and/or Administrators	John Hancock Life Ins. Co. Group Long-Term Care Division 529 Main Street X-3, Boston, MA 02129	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, Kentucky 40511-4590	Chase Manhattan Bank 4 Chase Metrotech Center Brooklyn, NY 11245
Payment of Claims	John Hancock Life Ins. Co.	Metropolitan Life Insurance Company	IBM Corporation

Table 2. ERISA Information		
Plan Name and Number	IBM Group Life Insurance and Survivors Income (501) IBM Regular Part-Time Employee Group Life Insurance and Survivor's Income Benefit Plan (510)	IBM Travel Accident Insurance Plan for Regular and Regular Part-Time Employees (507)
Plan Type	Life Insurance and Survivors Benefit	Accidental death and dismemberment
Administration	Insurance policy plus direct payment by IBM to eligible survivors	Insurance policy
Funding	Insurance premium based on claim experience and SIB payment from general assets of IBM	Insurance premium
Plan Trustee(s), Insurer(s) and/or Administrators	IBM Corporation and Prudential Ins. Co. of America 56 North Livingston Avenue Livingston, NJ 07068	Insurance Co. of North America 195 Broadway 11th Floor New York, NY 10007
Payment of Claims	IBM Corporation and Prudential Ins. Co. of America	Insurance Co. of North America

9.2 Changes to IBM Benefit Plans

IBM's benefit plans may be amended by written resolution of the Board of Directors or any Committee to which the Board has delegated power.

The Retirement Plans Committee is authorized to amend any Plan which is funded through a trust, including the IBM Medical Disability Income Plan. All other benefit plans may be amended by the IBM chief human resources officer or other IBM executive by means of a written instrument, such as the text of a plan, a summary plan description, a trust agreement, an insurance contract or insurance certificate, an administrative services contract, the administrative documents and procedures for a plan, an electronic medium notice, a hard copy bulletin board notice, or an announcement letter or written materials that are approved by said chief human resources officer or other IBM executive and maintained with the records of the affected benefit plan.

9.3 Claim Review Procedure

If an application for plan benefits is denied in whole or in part, written notice of the denial will be made to the claimant within a reasonable period of time after receipt of the claim. The notice of denial will include specific reasons for the denial with reference to the section of the plan on which denial is based, a description of any additional information necessary to resubmit the claim and an explanation of the claim review procedure. Within 60 days after receiving the denial, a claimant may request a review of the claim by writing to the Plan Administrator. A

prompt review will be made after a request is received. A written decision on the review will normally be furnished within 60 days after the appeal is received. (Where special circumstances require an exception, the Plan Administrator will provide written notice within the 60 days that the decision will be furnished as soon as possible, but not more than 120 days after the appeal was received.) The second notice will include the reasons for the decision with specific reference to pertinent plan provisions upon which the decision is based.

In connection with any request for a claim review of a denial of a benefit claim in which the beneficiary's medical condition is an issue or coverage was not pre-certified, IBM may require the patient to be examined by a physician(s) selected by IBM.

YOUR BENEFIT PLAN

INTERNATIONAL BUSINESS MACHINES CORPORATION

LONG TERM DISABILITY BENEFITS

Employees Hired as of December 31, 2003 and
Employees Hired On or After January 1, 2004
With More Than 5 Years of Service

Effective January 1, 2005

26612-117542

International Business Machines Corporation
New Orchard Road
Armonk, NY 10504

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

International Business Machines Corporation

MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	International Business Machines Corporation
Group Policy Number:	26612-1-G
Type of Insurance:	Disability Income Insurance: Long Term Benefits
MetLife Toll Free Number(s): For Claim Information	FOR DISABILITY INCOME CLAIMS: 1-800-638-0064

THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For Residents of North Dakota: If you are not satisfied with your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if you elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under your Certificate will not be covered.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-300-4296

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should You have a dispute concerning Your premium or about a claim You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-300-4296

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third
Little Rock, Arkansas 722014-1904
1-800-852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1 (800) 927-4357

NOTICE FOR RESIDENTS OF CONNECTICUT

MANDATORY REHABILITATION

This certificate contains a mandatory rehabilitation provision, which may require you to participate in vocational training or physical therapy when appropriate.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife you may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DISABILITY INCOME INSURANCE

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Disability Income Insurance ends because:

   - You cease to be in an Eligible Class; or
   - Your employment terminates

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Disability Income Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

CIVIL UNION NOTICE FOR RESIDENTS OF VERMONT

Vermont law provides that the following definitions apply to your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.

- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.

- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.

- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- "Civil Union" means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled "Act Relating to Civil Unions".

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of "dependent" as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in your certificate. It broadens definitions and terms only to the extent required by Vermont law.

DISCLOSURE:

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine your rights under this notice and the certificate to which it is attached.

FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:
1-800-275-4638

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209
1-800-552-7945 - In-state toll-free
1-804-371-9691 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

NOTICE FOR RESIDENTS OF ALL STATES
FRAUD WARNING

If You have applied for insurance under a policy issued in one of the following states, **or** if You reside in one of the following states, note the following applicable warning:

For Residents of New York - only applies to Accident and Health Insurance (AD&D/Disability/Dental)
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Florida
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

For Residents of Kansas and Massachusetts
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

For Residents of New Jersey
Any person who includes any false or misleading information on an application for an insurance policy or who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For Residents of Oklahoma
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Residents of Oregon
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

For Residents of Virginia
Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or statement of claim containing a false or deceptive statement may have violated state law.

For Residents of All Other States
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE FOR RESIDENTS OF ALL STATES

WORKERS' COMPENSATION
This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

MANDATORY DISABILITY INCOME BENEFIT LAWS
For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico
This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

Disability Income Insurance For You: Long Term Benefits

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS
Monthly Benefit You may choose the amount of your insurance from one of the following plans set forth below:	
Core Plan - Noncontributory Insurance.....	50% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Buy Up Plan - Contributory Insurance	66.67% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Minimum Monthly Benefit.....	$100.00 subject to the Overpayments and Rehabilitation Incentive subsections of this certificate.
Elimination Period.....	1. If You are not on an approved Leave of Absence, a total of 1,040 hours within any consecutive 12 month period when You are disabled and eligible to receive benefits under the Policyholder's short term disability plan. Long Term Benefits will begin if you continue to be Disabled after the 1,040 hour period of disability ends. 2. If Your disability starts on a day while you are on an approved Leave of Absence, and You continue to be disabled while You: a. remain on the Leave; or b. become eligible to receive benefits under the Policyholder's short term disability plan; Long Term Benefits will begin after a continuous period of 26 weeks of disability.

SCHEDULE OF BENEFITS (continued)

Maximum Benefit Period*

Age When Your Disability Benefit Begins	Benefit Period
Prior to age 60	To age 65
On or after age 60	5 years

* The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.

Rehabilitation Incentives
Work Incentive ..... Yes

Additional Benefits:

Portability..... Yes

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time or regular part-time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Appropriate Care and Treatment means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating Your Disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of Your Disability; and
- intended to maximize Your medical and functional improvement.

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the General Provisions section.

Contributory Insurance means insurance for which the Policyholder requires You to pay any part of the premium.

Contributory Insurance includes: Disability Income Insurance and any increase elected under a buy-up provision.

Disabled or **Disability** means that, due to Sickness or as a direct result of accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are,
  - after the Elimination Period and during the next 12 months of Sickness or accidental injury, unable to perform each of the material duties of Your Own Occupation with the Policyholder; and
  - after such period, unable to perform the duties of any gainful occupation for which You are reasonably qualified taking into account Your training, education and experience.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If Your occupation requires a license, the fact that You lose Your license for any reason will not, in itself, constitute Disability.

Elimination Period means the period of Your Disability during which We do not pay benefits. The Elimination Period begins on the day You become Disabled and continues for the period shown in the SCHEDULE OF BENEFITS.

DEFINITIONS (continued)

Full-Time means Active Work as an employee in the eligible class of employees to which You belong, for the time period determined by the Policyholder.

Local Economy means the geographic area:

- within which You reside; and
- which offers suitable employment opportunities within a reasonable travel distance.

If You move on or after the date You become Disabled, We may consider both Your former and current residence to be Your Local Economy.

Noncontributory Insurance means insurance for which the Policyholder does not require You to pay any part of the premium.

Own Occupation means the essential functions You regularly perform that provide Your primary source of earned income.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

Policyholder's Retirement Plan means a plan which:

- provides retirement benefits to Employees; and
- is funded in whole or in part by Policyholder contributions.

DEFINITIONS (continued)

The term does not include:

- profit sharing plans;
- thrift or savings plans;
- non-qualified plans of deferred compensation;
- plans under IRC Section 401(k) or 457;
- individual retirement accounts (IRA);
- tax sheltered annuities (TSA) under IRC Section 403(b);
- stock ownership plans; or
- Keogh (HR-10) plans.

Predisability Earnings means:

- If you are classified as an executive, the gross base salary plus the incentive pay You were earning from the Policyholder as of Your last day of Active Work before Your Disability began, as determined by the Policyholder. This amount is calculated on a monthly basis.

- If you are classified as a salaried employee, Your gross regular monthly compensation that You were earning from the Policyholder for regularly scheduled hours up to 40 hours per week, as determined by the Policyholder, as of Your last day of Active Work before Your Disability began.

- If You are classified as a commissioned employee, Your on-target earnings, as defined by the Policyholder, that You were earning from the Policyholder on Your last day of Active Work before Your Disability began.

The term Predisability Earnings includes:

contributions You were making through a salary reduction agreement with the Policyholder to any of the following:

- an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
- an executive non-qualified deferred compensation arrangement; and
- Your fringe benefits under an IRC Section 125 plan.

The term Predisability Earnings does not include:

- awards;
- overtime pay;
- the Policyholder's contributions on Your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation from the Policyholder.

DEFINITIONS (continued)

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Rehabilitation Program means a program that has been approved by Us for the purpose of helping You return to work. It may include, but is not limited to, Your participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

Sickness means illness, disease or pregnancy, including complications of pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful Spouse.

We, **Us** and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Full-Time and regular part-time employees of the Policyholder, but not temporary or seasonal employees.

Eligible classes include executives, salaried employees and commissioned employees:

- Hired on or before December 31, 2003; or
- Hired on and after January 1, 2004, who have at least 5 years of service.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on January 1, 2005, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2005, You will be eligible for insurance on the date You enter that class.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The insurance listed below is part of a benefits plan established by the Policyholder. Subject to the rules of the benefits plan and the Group Policy, You may enroll for:

- Disability Income Insurance: Long Term Benefits;

only when You are first eligible or during an annual enrollment period. You should contact the Policyholder for more information regarding the benefits plan.

DATE YOUR INSURANCE THAT IS PART OF THE NONCONTRIBUTORY BENEFITS PLAN TAKES EFFECT

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at work on that date.

DATE YOUR INSURANCE THAT IS PART OF THE CONTRIBUTORY BENEFITS PLAN TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible for such insurance if You are Actively at Work on that date.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, the benefit will take effect on the date We state in Writing, provided You are Actively at Work on that date.

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period, as determined by the Policyholder, following the

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

date You first became eligible. At that time You will be able to enroll for insurance for which You are then eligible.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment During First Annual Enrollment Period Following the Date You Became Eligible

If You complete the enrollment process at the first annual enrollment period following the date You became eligible for such insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Enrollment During Any Subsequent Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The insurance enrolled for or changes to Your insurance made during an annual enrollment period will take effect as follows:

- for any amount for which You are **not required** to give evidence of Your insurability, such insurance will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date.
- for any amount for which You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work.

Request To Change The Amount of Your Disability Income Insurance

You may request a change in the amount of Disability Income Insurance in effect on You under this certificate. You may request such change by notifying the Policyholder of Your request and sending Proof of the change to Us.

Please refer to the enrollment and effective date of insurance rules described in ENROLLMENT PROCESS and the DATE INSURANCE THAT IS PART OF THE CONTRIBUTORY BENEFITS PLAN TAKES EFFECT provision in this section. These rules determine when You may request to change the amount of Your Disability Income Insurance and when the change will take effect.

If You elect Noncontributory Disability Income Insurance when You are first eligible for such insurance under this certificate, and later You request a change to Contributory Disability Income Insurance, the change in the amount of Your Monthly Benefit is subject to the DATE INSURANCE THAT IS PART OF THE CONTRIBUTORY BENEFITS PLAN TAKES EFFECT provision in this section.

If You elect Contributory Disability Income Insurance when You are first eligible for insurance under this certificate, and later:

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

- You fail to make the required premium payment when due, You will become insured for Noncontributory Disability Income Insurance and the amount of Your Monthly Benefit will be adjusted to the amount shown in the Schedule of Benefits for Noncontributory Disability Income Insurance subject to the DATE INSURANCE THAT IS PART OF THE NONCONTRIBUTORY BENEFITS PLAN TAKES EFFECT provision in this section; or

- You request a change to a Noncontributory amount of Disability Income Insurance, the change in the amount of Your Monthly Benefit is subject to the DATE INSURANCE THAT IS PART OF THE NONCONTRIBUTORY BENEFITS PLAN TAKES EFFECT provision in this section.

Changes in Your Disability Income Insurance will only apply to Disabilities commencing on or after the date of the change.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. for Disability Income Insurance: Long Term Benefits, the date You cease to be in an eligible class. You will cease to be in an eligible class on the last day of the calendar month in which You cease Active Work in an eligible class, if You are not disabled on that date; or
5. for Disability Income Insurance: Long Term Benefits, the date You retire in accordance with the last day of the calendar month in which Your employment ends; or
6. for Disability Income Insurance: Long Term Benefits, the last day of the calendar month in which Your employment ends.

Please refer to the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT for information concerning Continuation For Family and Medical Leave and continuation of the insurance at the Policyholder's option.

Reinstatement of Disability Income Insurance

If Your insurance ends, You may become insured again as follows:

1. If Your insurance ends because the required premium for Your insurance has ceased to be paid due to Your being on an approved Family Medical Leave Act (FMLA) leave of absence, and You become a member of an eligible class within 31 days of the earlier of:

   - The end of the period of leave You and the Policyholder agreed upon; or
   - The end of the 12-week period following the date Your leave began,

   You will not have to provide evidence of Your insurability.

2. In all other cases where Your insurance ends because the required premium for Your insurance has ceased to be paid, You will be required to provide evidence of Your insurability.

If You become insured again as described in item 1, the limitation for Pre-existing Conditions will be applied as if Your insurance had remained in effect with no interruption.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) for continuation of insurance. Please contact the Policyholder for information regarding the FMLA.

AT YOUR OPTION: PORTABILITY

For Disability Income Insurance

For purposes of this subsection the term "Portability Eligible Disability Income Insurance" refers to Disability Income Insurance: Long Term Benefits.

You may request in Writing during the Request Period specified below to continue Your Portability Eligible Disability Income Insurance under another group policy issued by MetLife if such insurance ends because You cease to be in an eligible class or Your employment ends.

If You make a request under this subsection, evidence of Your insurability will not be required. We will issue a new certificate of insurance which will explain Your new insurance benefits. Your insurance benefits under the new certificate may not be the same as those that ended under the Group Policy.

A request under this subsection may be made, if, on the date of Your request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Policyholder of its intent to end the Group Policy;
- You reside in a jurisdiction that permits portability;
- You have been insured for at least 12 months prior to the date that Your employment ends;
- Your employment did not end as a result of Your retirement;
- You are not Disabled; and
- You have not become insured under any other disability insurance plan within 31 days after the date Your Portability Eligible Disability Income Insurance ends under the Group Policy.

Request Period

To continue Your Portability Eligible Disability Income Insurance under a different group policy, We must receive a completed request form from You within 31 days after the date such insurance ends under this certificate.

Your new certificate will take effect on the day after Your Portability Eligible Disability Income Insurance ends under this Certificate.

Premiums for the New Certificate

When You request to continue Portability Eligible Disability Income Insurance under this subsection, the first premium must be paid within 31 days after Your insurance ends under this certificate. All premiums must be paid directly to Us. When We issue the new certificate, We will also provide You with a schedule of premiums and payment instructions.

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for his employees who are not Disabled and cease Active Work in an eligible class for any of the reasons specified below:

Disability Income Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or Sickness, up to 3 months;

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

2. for the period You cease Active Work in an eligible class due to a Policyholder approved leave of absence, up to 36 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the Date Your Insurance Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. in order for You to increase the amount of Your Disability Income Insurance. If You do not give Us evidence of insurability or the evidence is not accepted by Us as satisfactory, the amount of Your Disability Income Insurance will not be increased.
2. if You make a late request for more than 31 days after You become eligible.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Long Term Disability Insurance.

The evidence of insurability is to be given at Your expense.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Monthly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to THE DATE BENEFIT PAYMENTS END section.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While You are Disabled, the Monthly Benefit described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

BENEFIT PAYMENT

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Monthly Benefit on the date which occurs on the first day of the month after the date benefits begin to accrue. We will make subsequent payments monthly thereafter so long as You remain Disabled. Payment will be based on the number of work days for the month in which You are Disabled.

We will pay Monthly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

While You are receiving Monthly Benefits, You will not be required to pay premiums for the cost any disability income insurance defined as Contributory Insurance.

RECOVERY FROM A DISABILITY

If You return to Active Work, We will consider You to have recovered from Your Disability.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group long term disability plan.

If You Return to Active Work Before Completing Your Elimination Period

If You return to Active Work before completing Your Elimination Period for a period of 45 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 45 days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work only includes those days You actually work.

If You Return to Active Work After Completing Your Elimination Period

If You return to Active Work after completing Your Elimination Period for a period of 90 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)

If You return to Active Work for a period of more than 90 days and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work includes all of the continuous days which follow Your return to work for which You are not Disabled.

REHABILITATION INCENTIVES

Work Incentive

While You are Disabled, We encourage You to work. If You work while You are Disabled and receiving Monthly Benefits, Your Monthly Benefit will be adjusted as follows:

- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Monthly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Monthly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability.

In addition, the Minimum Monthly Benefit will not apply.

Limit on Work Incentive

After the first 24 months following Your Elimination Period We will reduce Your Monthly Benefit by 50% of the amount You earn from working while Disabled.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT

We will reduce Your Disability benefit by the amount of all Other Income. Other Income includes the following:

1. any disability benefits which You, Your Spouse or child(ren) receive or are eligible to receive because of Your disability under:
   - Federal Social Security Act;
   - any state or public employee retirement or disability plan.
2. any income received for disability or retirement under the Policyholder's Retirement Plan, to the extent that it can be attributed to the Policyholder's contributions.
   - a no-fault auto law for loss of income, excluding supplemental disability benefits;
   - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to Your disability, whether such payment is made directly by the plan or program, or through a third party;
   - a self-funded plan, or other arrangement if the Policyholder contributes toward it or makes payroll deductions for it;
   - any sick pay, vacation pay or other salary continuation that the Policyholder pays to You;
   - workers compensation or a similar law which provides periodic benefits;
   - occupational disease laws.
3. any income that You receive from working while Disabled to the extent that such income reduces the amount of Your Monthly Benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.

REDUCING YOUR DISABILITY BENEFIT BY THE ESTIMATED AMOUNT OF YOUR SOCIAL SECURITY BENEFITS

If there is a reasonable basis for You to apply for benefits under the Federal Social Security Act, We expect You to apply for them. To apply for Social Security benefits means to pursue such benefits until You receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

We will reduce the amount of Your Disability benefit by the amount of Social Security benefits We estimate that You, Your Spouse or child(ren) are eligible to receive because of Your Disability. We will start to do this after You have received 24 months of Disability benefit payments, unless We have received:

- approval of Your claim for Social Security benefits; or
- a notice of denial of such benefits indicating that all levels of appeal have been exhausted.

However, within 6 months following the date You became Disabled, You must:

- send Us Proof that You have applied for Social Security benefits;
- sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance; and
- sign a release that authorizes the Social Security Administration to provide information directly to Us concerning Your Social Security benefits eligibility.

If You do not satisfy the above requirements, We will reduce Your Disability benefits by such estimated Social Security benefits starting with the first Disability benefit payment coincident with the date You were eligible to receive Social Security benefits.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

In either case, when You do receive approval or final denial of Your claim for Social Security benefits as described above, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment.

SINGLE SUM PAYMENT

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability Benefit by the amount of such payment.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR DISABILITY BENEFIT

We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS, or by:

- cost of living adjustments that are paid under any of the above sources of Other Income;
- reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of Your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by You;
- veteran's benefits;
- individual disability income insurance policies;
- benefits received from an accelerated death benefit payment; or
- amounts rolled over to a tax qualified plan unless subsequently received by You while You are receiving benefit payments.

DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END

Your Disability benefit payments will end on the earliest of:

- December 31 of the calendar year in which You begin to receive Benefits for Your Disability. The Policyholder may elect to continue Your Disability benefit payments for successive calendar year periods, subject to the Maximum Benefit Period, by:
  - giving written notice to Us; and
  - paying the required premium to Us;
- the date benefits end as specified in the section entitled LIMITED DISABILITY BENEFITS;
- the date You are no longer Disabled;
- the date You die;
- the date You cease or refuse to participate in a Rehabilitation Program that We require;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date You fail to provide required Proof of continuing Disability.

While You are Disabled, the benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

DISABILITY INCOME INSURANCE: PRE-EXISTING CONDITIONS

Pre-existing Condition means a Sickness or accidental injury for which You:

- received medical treatment, consultation, care, or services;
- took prescription medication or had medications prescribed; or
- had symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment;

in the 3 months before Your insurance or any increase in the amount of insurance under this certificate takes effect.

We will not pay benefits, or any increase in benefit amount due to an elected increase in the amount of Your insurance for a Disability that results from a Pre-existing Condition, if You have been Actively at Work for less than 12 consecutive months after the date Your Disability insurance or the elected increase in the amount of such insurance takes effect under this certificate.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS LIMITED DISABILITY BENEFITS

For Disability Due to Alcohol, Drug or Substance Addiction

If You are Disabled due to alcohol, drug or substance addiction, We will limit Your Disability benefits to one period of Disability during your lifetime. During Your Disability, We require You to participate in an alcohol, drug or substance addiction recovery program recommended by a Physician.

We will end Disability benefit payments at the earliest of:

- the date You receive 24 months of Disability benefit payments;
- the date You cease or refuse to participate in the recovery program referred to above; or
- the date You complete such recovery program.

For Disability Due to Mental or Nervous Disorders or Diseases, neuromusculoskeletal and soft tissue disorder, chronic fatigue syndrome and related conditions

1. If You are Disabled due to a Mental or Nervous Disorder or Disease, We will limit Your Disability benefits to a lifetime maximum equal to the lesser of:

   - 24 months; or
   - the Maximum Benefit Period.

   This limitation will not apply to a Disability resulting from:

   - schizophrenia;
   - dementia; or
   - organic brain disease.

2. If You are Disabled due to neuromusculoskeletal and soft tissue disorder including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the Disability has objective evidence of:

   - Seropositive Arthritis;
   - Spinal Tumors, malignancy, or Vascular Malformations;
   - Radiculopathies;
   - Myelopathies;
   - Traumatic Spinal Cord Necrosis; or
   - Musculopathies,

   We will limit Your Disability benefits to a lifetime maximum equal to the lesser of:

   - 24 months; or
   - the Maximum Benefit Period.

3. If You are Disabled due to Chronic fatigue syndrome and related conditions, We will limit Your Disability benefits to a lifetime maximum equal to the lesser of:

   - 24 months; or
   - the Maximum Benefit Period.

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS LIMITED DISABILITY BENEFITS (continued)

Mental or Nervous Disorder or Disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders as of the date of Your Disability. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

Seropositive Arthritis means an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease.

Spinal means components of the bony spine or spinal cord.

Tumor(s) means abnormal growths which may be malignant or benign.

Vascular Malformations means abnormal development of blood vessels.

Radiculopathies means disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology.

Myelopathies means disease of the spinal cord supported by objective clinical findings of spinal cord pathology.

Traumatic Spinal Cord Necrosis means injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis.

Musculopathies means disease of muscle fibers, supported by pathological findings on biopsy or electromyography (EMG).

DISABILITY INCOME INSURANCE: EXCLUSIONS

We will not pay for any Disability caused or contributed to by:

1. Your active participation in a riot;
2. intentionally self-inflicted injury;
3. attempted suicide; or
4. commission of or attempt to commit a felony.

FILING A CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR INSURANCE BENEFITS

When a claimant files an initial claim for Disability Income Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss.

Notice of claim and Proof may also be given to Us by following the steps set forth below:

Step 1
A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2
We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

Step 3
When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required Proof described in the claim form. If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4
The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Items to be Submitted for a Disability Income Insurance Claim

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
  - Your application for:
    - Other Income;
    - Social Security disability benefits; and
    - Workers compensation benefits or benefits under a similar law.
- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Income;

FILING A CLAIM (continued)

- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
    - histories,
    - physical, mental or diagnostic examinations; and
    - treatment notes; and
- the names and addresses of all:
  - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
  - pharmacies which have filled Your prescriptions within the past three years.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law.

Disability Income Benefit Payments: Who We Will Pay

We will make any benefit payments during Your lifetime to You or Your legal representative. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Upon Your death, We will pay any amount that is or becomes due to Your designated Beneficiary. If there is no Beneficiary designated or no surviving Beneficiary at Your death we will pay any benefit that is or becomes due, according to the following order:

1. Your Spouse, if alive;
2. Your unmarried child(ren) under age 25; if there is no surviving Spouse; or
3. Your estate, if there is no such surviving child.

If more than one person is eligible to receive payment, We will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to Your estate may be paid in a single sum. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to contest insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

GENERAL PROVISIONS (continued)

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Overpayments for Disability Income Insurance

Recovery of Overpayments

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

- the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us. Our rights and Your obligations in this regard are described in the reimbursement agreement that You are required to sign when You submit a claim for benefits under this certificate. This agreement:

- confirms that You will reimburse Us for all overpayments; and
- authorizes Us to obtain any information relating to sources of Other Income.

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future Disability benefits, including the Minimum Benefit, payable to You or any other payee under the Disability sections of this certificate;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

THIS IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

SPECIAL SERVICES

Social Security Assistance Program

If you become Disabled, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply For Social Security Disability Benefits

Both you and your employer contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your Disability. There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. **Avoids Reduced Retirement Benefits**

   Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

2. **Medicare Protection**

   Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. **Trial Work Period**

   Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

4. **Cost-of-Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits**

   MetLife will not decrease your Disability benefit by the periodic cost- of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children.

   This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your Disability benefit; with the following exceptions:

   a) an error by Social Security in computing the initial amount;

   b) a change in dependent status; or

   c) your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

   Over a period of years, the net effect of these cost-of-living increases can be substantial.

How MetLife Assists You in the Social Security Approval Process

As soon as you apply for Disability benefits, MetLife begins assisting you with the Social Security approval process.

SPECIAL SERVICES

1. **Assistance Throughout the Application Process**

   MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They provide expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

2. **Guidance Through Appeal Process by Social Security Specialists**

   Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provides expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

   a) Reconsideration by the Social Security Administration

   b) Hearing before an Administrative Law Judge

   c) Review by an Appeals Council established within the Social Security Administration in Washington, D.C.

   d) A civil suit in Federal Court

3. **Social Security Attorneys**

   Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long Term Disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security Disability benefits award and will not be used to further reduce your Long Term Disability benefit.

Early Intervention Program

The MetLife Early Intervention Program is offered to all covered employees, and your participation is voluntary*. The program helps identify early those employees who might benefit from vocational analyses and rehabilitation services before they are eligible for Long Term Disability benefits. Early rehabilitation efforts are more likely to reduce the length of your Long Term Disability and help you return to work sooner than expected.

If you cannot work, or can only work part-time due to a disability, your employer will notify MetLife. Our Clinical Specialists may be able to assist you by:

1. Reviewing and evaluating your disabling condition, even before a claim for Long Term Disability benefits is submitted (with your consent);
2. Designing individualized return to work plans that focus on your abilities, with the goal of return to work;
3. Identifying local community resources;
4. Coordinating services with other benefit providers, including: medical carrier, short term disability carrier,* workers' compensation carrier, and state disability plans;
5. Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).

Our assistance is offered at no cost to either you or your employer.

* If you also have MetLife Short Term Disability coverage or Salary Continuance Plan Management, these services are provided automatically. Notification by your employer is not necessary.

SPECIAL SERVICES

Return To Work Program

Goal of Rehabilitation
The goal of MetLife is to focus on employees' abilities, instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what employees can do versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work
Your Disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable, but you do not participate in the Return to Work Program, your Disability benefits may cease.

Return-to-Work Services
As a covered employee you are automatically eligible to participate in our Return-to-Work Program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities.
There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analyses**

   Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your employer.

2. **Labor Market Surveys**

   Studies to find jobs available in your locale that would utilize your abilities and skills. Also identify one's earning potential for a specific occupation.

3. **Retraining Programs**

   Programs to facilitate return to your previous job, or to train you for a new job.

4. **Job Modifications/Accommodations**

   Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities.

   This also includes changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your employer under the Americans With Disabilities Act (ADA).

5. **Job Seeking Skills and Job Placement Assistance**

   Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Return-to-Work Program Staff
The Case Manager handling your claim will coordinate return-to-work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as well as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

SPECIAL SERVICES

Rehabilitation Vendor Specialists
In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. attending physician's evaluation and recommendations;
2. your individual vocational needs; and
3. vendor's credentials, specialty, reputation and experience.

When working with vendors, we continue to collaborate with you and your doctor to develop an appropriate return-to-work plan.

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

International Business Machines Corporation
New Orchard Road
Armonk, NY 10504

EMPLOYER IDENTIFICATION NUMBER:

PLAN NUMBER	COVERAGE	PLAN NAME
525	Disability Income Insurance: Long Term Benefits	The IBM Long Term Disability Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which Metlife is liable for Disability Income Insurance: Long Term Benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accord with the "Date Your Insurance Ends" subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

CONTRIBUTIONS AND RETROSPECTIVE EXPERIENCE RATE REFUND

This means that favorable experience under this insurance coverage for one or more years may be held in reserve and used to offset unfavorable experience in other years for the optional life insurance benefit only. If experience is favorable or unfavorable for sustained periods, upon the advice of our actuaries, employee contributions may be reduced or increased. In some years, the Plan Administrator may make a contribution to the Plan to offset unfavorable experience, but is not obligated to do so.

Retrospective experience rate refunds declared by the insurer under the group insurance policy or policies may be used to reduce the Plan Administrator's cost for the coverages in the same or prior years. In the unlikely event that total retrospective experience rate refunds were to exceed the Plan Administrator's cumulative costs for the coverage, the excess would be used for the benefit of employees covered by the group insurance policies.

International Business Machines Corporation has in the past, and expects in the future, to pay a substantial share of the combined cost of the insurance coverages, it is unlikely that any such excess of In view of the fact that retrospective experience rate refunds over International Business Machines Corporation's costs will occur.

You must make a contribution to the cost of Disability Income Insurance: Long Term Benefits–Buy Up Plan – Contributory Insurance. No contribution is required if you only have the Core Plan- Noncontributory Insurance.

The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a plan year basis beginning each January 1 and ending on the following December 31.

Qualified Domestic Relations Orders/Qualified Medical Child Support Orders

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Disability Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

For claims for disability benefits, the claimant must report the claim to MetLife and, if requested, complete the appropriate claim form. The claimant must also submit the required proof as described in the "Filing A Claim" section of the certificate.

Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you

such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request,

MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but International Business Machines Corporation reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of International Business Machines Corporation shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.